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Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____Colorado_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Karen Reinertson	Position/Title: Executive Director, Colorado Department of Health Care Policy and Financing
Name: Marilyn Golden	Position/Title: Division Director for the Office of Operations and Finance
Name: Barbara Ladon	Position/Title: Director, Child Health Plan Plus Division

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 X Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ~ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ~ A combination of both of the above.

1.2 X Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 X Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: July 1, 2002

Implementation date: February 1, 2002*

* Implementation of new Dental Benefit.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

See Attachment 2 for a description of children's insurance status by income and race and ethnicity.

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Colorado identifies and enrolls children eligible to participate in public health insurance programs through a significantly broad outreach strategy through both public and private partners and through direct appeals to families in the media and in their communities. Significantly, one of the most successful efforts after five years of operation has been and continues to be word of mouth that has been generated by the positive experiences of members and local partners.

One important method of enrollment that has simplified the process for families is the development of a simplified, joint application that partners and the agency can use to enroll children and families in both Medicaid or Child Health Plan *Plus*. This simplified application can be obtained through the standard Medicaid outreach and enrollment process, as well as through the standard Child Health Plan *Plus* outreach and enrollment processes.

1. Medicaid, administered by the Colorado Department of Health Care Policy and Financing, provides health coverage to low-income children and families, elderly and disabled Coloradans. Colorado takes the following steps to enroll children in Medicaid:

- County social services departments determine a person's eligibility for Medicaid. Presumptive eligibility sites (Federally Qualified Health Centers and Planned Parenthood clinics), county nurses offices, doctor's offices and Indian Health Centers determine presumptive Medicaid eligibility and enroll pregnant women. Infants up to twelve months old born to Medicaid-enrolled

women are guaranteed Medicaid eligibility for twelve months.

- Outstationed eligibility sites (FQHCs, Disproportionate Share Hospitals, and local county health departments) help people apply for Medicaid by collecting and sending their applications and paperwork to the county department of social services office for eligibility determination.

- Posters, brochures, and a 1-800 number provide Medicaid information to potentially eligible families at several locations, including public assistance offices**.**

- The Child Health Plan *Plus* (CHP+) screens applicants for Medicaid eligibility. When an applicant appears to be Medicaid eligible: the CHP+ central office refers applications to Medicaid technicians located at the CHP+ office who process the application for the family. This process accelerates enrollment. Satellite eligibility determination sites refer directly to county department of social services for application processing.

2. The Child Health Plan *Plus* (CHP+) is a public/private partnership providing subsidized health insurance for children in low-income families statewide who are not eligible for Medicaid. The CBHP Policy Board provided oversight and policy development. CHP+ is administered by the Department of Health Care Policy and Financing through private contractors who provide various services. These organizations manage the routine administrative matters associated with CHP+.

National data and three years of experience have shown that reaching out on a local level is the most effective way to reach eligible families. CHP+ has continued its efforts to partner with many community-based organizations throughout the year. CHP+ created partnerships with approximately 2000 community-based organizations including: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children programs; and many others. These extensive partnerships represent an extraordinary commitment statewide to enroll uninsured children as part of the CHP+ comprehensive marketing and outreach strategy. In addition, CHP+ program initiated a targeted television advertising campaign and began testing employer-based outreach activities. All of these activities represent Colorado's interest in reaching families in every way possible.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership.

CHP+ has created an extensive marketing and outreach program encompassing strategies that range from grass roots networking to mass market advertising campaigns. These efforts have been implemented to reach families many different ways with different messages**.**

To better evaluate the effectiveness of these strategies, CHP+ implemented a large-scale, application-source tracking system in March 2000. The system allows an application to be traced back to the initial source without relying on self-reported referral data. This tracking system will continue to be used to monitor trends and results from marketing and outreach campaigns.

Community-Based Partnerships:

A cornerstone of the CHP+ outreach strategy is to maintain and build on community partnerships. To reach all eligible families through as many avenues as possible, CHP+ works with more than 2000 partners. These include: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children nutrition programs; faith-based organizations and a myriad of others. Experience has shown that multiple contacts throughout the community are important to the eventual enrollment of an eligible child.

Hispanic-Related Partnerships:

In order to reach the substantial Hispanic population in Colorado, CHP+ has partnered specifically with LARASA and the Mexican Consulate to explore appropriate avenues to reach this subpopulation. LARASA staffs a CHP+ advisory council that represents Hispanic business, faith-based and community service leaders. These community leaders advise CHP+ regarding the special needs of the Hispanic population.

Managed Care Organizations:

One method of partnering has been the implementation of joint media campaigns in which four of the six managed care organization partners have participated. These purchased advertisements were structured so that each partner received air time when marketing would be most effective.

Most managed care partners have committed extensive time and effort to reach disenrollees, as well as to find new enrollees through advertisements, partnerships and events. All of CHP+'s managed care partners participate in various community events throughout the state.

Advertising and Earned Media:

CHP+ experienced an increased number of applications from concentrated advertising campaigns. Spikes in requests for information are consistently noted after television advertisements or newspaper stories about the program appear. Television continues to rank as the highest source of referral for individual applications. CHP+ and managed care

organizations team together to purchase targeted television advertisements because they are so effective.

County Departments of Social Services:
County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child care and Colorado Works. Many CHP+ referrals come from these programs. In addition, because federal law mandates linkage between CHP+ and Medicaid (for example, through a common application) about 20% of CHP+ applications are submitted through the Medicaid application process managed directly by county departments of social services.

Satellite Eligibility Determination Sites:
CHP+ has a network of 73 satellite eligibility determination sites statewide, including multiple locations for some sites. These sites comprise community health centers, county nursing services, school-based health centers and other community providers, and have been an essential component of the programs outreach and enrollment activities. As part of their contract with CHP+, they are required to provide outreach to their community for CHP+ and have access to an on-line enrollment system to accelerate program enrollment.

Schools:
Schools are consistently one of the most frequently cited sources of referral by applicants. Increasing numbers of school districts are partnering with CHP+ to assure the children they serve know about the program.

Community Health Centers:
The Colorado Community Health Network has made involving its members in Medicaid and CHP+ outreach a priority. Community health centers are the largest group of primary care providers throughout the state serving low-income children. Some serve as satellite eligibility determination sites while others participate in community coalitions to enroll children in Medicaid and CHP+.

Covering Kids Colorado:

A significant partner in developing community-based outreach has been Covering Kids Colorado, which is a Robert Wood Johnson Foundation funded grant program administered by the Colorado Department of Public Health and Environment. The program has focused on three distinct communities, Denver City and County along with Adams and Prowers Counties, to assure all children eligible for CHP+ and Medicaid are enrolled in their respective programs. Covering Kids has employed a community-based partnership strategy similar to the one used by CHP+.

Colorado has received a Covering Kids and Families Grant from the Robert Wood Johnson Foundation in 2002. This grant will be administered by a coalition of community groups including the Colorado Community Health Network, the Colorado

Childrens' Campaign and Catholic Charities. The program will focus on three distinct communities, Denver City and County, the Mountain ski area counties of Eagle, Pitkin and Garfield, and Pueblo City and County.

Community Voices:
Denver Health and Hospital Corporations Community Voices program is a joint Kellogg Foundation and Colorado Trust funded program, which has among its goals to improve the health of Denver's medically underserved through innovations in community outreach, enrollment in publicly funded health insurance programs like CHP+, as well as small employment health plans, and clinical case management. Community Voices efforts are designed to demonstrate that culturally sensitive community outreach to underserved populations improves enrollment of eligible individuals into plans, while engaging and empowering communities to assume greater responsibility for health.

Indian Health Services:
CHP+ has contracts with Indian Health Services in all areas of the state to allow tribal clinics to deliver health care to Native Americans.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. ***(Previously 4.4.5.)***
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

1. The Health Care Program for Children with Special Needs (HCP) is a joint state/federal program administered by the Colorado Department of Public Health and Environment for children age 20 and under who have a physical disability that interferes with normal growth and development. HCP helps pay medical bills and provides follow-up for children diagnosed with a clinically qualifying handicapping condition. Children with conditions eligible for the program are identified through county nursing services, health care providers, Child Find coordinators in public schools, and local Early Childhood Connections staff.

2. Colorado Indigent Care Program (CICP), administered by the Colorado Department of Health Care Policy and Financing, is a state and federally funded provider reimbursement program that discounts the cost of medical care at its participating health facilities for adults as well as children. If a person is eligible for Medicaid or CHP+, he or she is ineligible for CICP. Covered services vary by participating hospitals or clinics, but generally include hospital costs such as inpatient stays, surgery, and prescription drugs. All children deemed eligible for the above mentioned programs are directed toward them at CICP-participating providers. Colorado takes the following steps to enroll children in the Colorado Indigent Care Program (CICP):

- CICP-contracted providers (primarily FQHCs, DSH hospitals, and participating clinics) screen children for CICP eligibility during their visit, assist with completing the application, and determine eligibility for the program.

- The non-CICP community health centers and other safety net providers who determine Medicaid eligibility refer clients to a CICP provider if they determine that a client is not eligible for Medicaid, but may be eligible for CICP. Children are referred to CHP+ first if the safety net providers determine that a client is not eligible for Medicaid.

3. Cover Colorado, established in 1990 by the Colorado General Assembly as a quasi-governmental entity, provides health insurance to individuals, including children, who are denied commercial health insurance by private carriers because of a pre-existing medical condition. Cover Colorado and CHP+ often compare enrollment and disenrollment information to discern trending that may be relevant to both programs.

4. Community health centers offer a wide range of health care to people who may need some financial assistance with their medical bills. Colorado has 15 community health centers with more than 50 clinic sites in medically under-served areas of the state. Community health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, emergency care, diagnostic services and prescriptions.

Community Health Centers, many of who are Federally Qualified Health Centers, take the following steps to enroll children in Medicaid, CHP+, the Colorado Indigent Care Program, or the health centers sliding fee scale plan:

- Provide a financial screen for each new patient or family.
- Provide information on and explanation of the program(s) that the family members are eligible for.
- Assist with completing applications and collecting necessary documentation for eligibility determination.
- Determine eligibility on-site or forward applications to the determining agency and communicate with family about eligibility status.
- Assist families when their financial situation and eligibility changes to transition to the appropriate program.

If a patient/family is not eligible for any program, the health center uses its sliding fee scale to determine the fee according to family size and income.

5. County public health departments identify low income, uninsured children through referrals from a variety of sources including: Women, Infant and Children (WIC), child

health and immunization clinics, other community health providers (including private physicians), community health and social services agencies and schools, Headstart centers, Early Childhood Connections (Part C), homeless shelters, and self-referrals. Public health staff refer families to any available health care insurance source for which they appear to be eligible, including Medicaid and CHP+ and work with local physicians to try and secure services on a reduced-fee basis. Many public health agency staff assist families in completing application forms for Medicaid and the CHP+. In Colorado, Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) outreach workers and administrative case managers are a part of local public health agency staff who facilitate access to Medicaid and to CHP+ services for eligible children.

6. Maternal and Child Health Block Grant (Title V of the Social Security Act) funds in Colorado are "passed through" to local public health agencies and other qualified non-profit agencies where they are used to support a number of activities on behalf of women and children, particularly those of low income. State Title V staff provide oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e. community or rural health centers) available or accessible, these public health agencies provide direct services to low- income children. Services provided in local public health agencies are almost always provided by public health nurses. Services include comprehensive well child clinic services, including developmental and physical assessments, immunizations, and parent education. Families under 100% FPL pay nothing for these services. Others pay on a sliding fee scale.

7. School-based health centers (SBHC) provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, some diagnostics services and prescriptions. SBHCs provide services at no charge. However, patients are asked whether or not they have health care coverage. The degree to which the SBHCs bill for reimbursement depends on the administrative capabilities of the center and whether a CHP+ participating managed care organization contracts with them. SBHCs facilitate application to Medicaid, CHP+ or CICP when documentation of family income and assets is obtainable without jeopardizing students confidentiality.

8. The Special Nutritional Program for Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below 185% of the federal poverty level. WIC staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid and CHP+.

9.The Commodity Supplemental Food Program (CSFP) provides infant formula and nutritious foods to supplement the diet of pregnant and postpartum women and children under age 6. Women who live in Conejos, Costillo, Denver, Mesa, Rio Grande or Weld

counties and who have a combined family income at or below 185% of the federal poverty level qualify for the program. Staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid and CHP+.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

~ **Check here if the state elects to use funds provided under Title XXI only to provide**

expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

The program uses MCOs for health care delivery services. The statewide provider network established by the former Colorado Child Health Plan has been expanded to care for children who are eligible for CHP+ but who have not yet been enrolled in a HMO (HMOs generally initiate coverage on the first of the month only) and those children who live in areas where no service is available.

Health Maintenance Organizations

State legislation (House Bill 97-1304) requires that only plans willing to contract with Medicaid are eligible to serve CHP+ clients. This will ensure that clients are not forced to change providers each time their financial situation changes the program for which they are eligible (Medicaid or CHP+). The CHP+ program contracts with managed care organizations serving a significant number of commercial and Medicaid clients statewide. These plans vary in structure, service area and membership.

Contract standards are based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and Quality Improvement System for Managed Care (QISMC) standards.

CHP+ HMO contractors have to pass the examination of three entities: the Colorado Division of Insurance (DOI), the Department of Public Health and Environment (CDPHE) and the Colorado Department of Health Care Policy and Financing (HCPF). The DOI grants HMO licenses based on a review of financial stability, adequate provider subcontracts, access to care and quality of care. The DOI subcontracts the quality and access review to the CDPHE. When a licensed plan applies for a Medicaid contract, HCPF reviews several aspects of the plans operation including provider network, utilization, management, access to care, quality improvement and grievance procedures. HCPF reviews the Medicaid plans that apply to serve CHP+ clients. Where CHP+ contract standards vary from those of DOI and HCPF, the Department conducts additional reviews in coordination with the Medicaid, DOI, CDPHE, or other purchaser reviews.

Essential Community Providers: As required by state legislation (House Bill 97-1304), Child Health Plan Plus only contracts with HMOs that are willing to contract with the Colorado Medicaid program. To retain their Medicaid contracts, these HMOs must fulfill the statutory requirements of SB 97-75 with regard to use of ECPs. Therefore, the CHP+ managed care network includes these providers. ECPs include community health centers, community mental

health centers, public health agencies, school-based clinics, family planning clinics, and other indigent care providers.

Self-Insured Managed Care Network

The former Colorado Child Health Plan developed its own statewide provider network, with provider contracts held by the University of Colorado Health Sciences Center (UCHSC). UCHSC held those contracts through a Memorandum of Understanding with the Department through June 30, 1999. As of July 1, 1999, HCPF has taken over responsibility for provider contracts. The Department contracts with a single entity to manage all aspects of the self-insured managed care network. These physicians, hospitals and ancillary service providers provide services covered by the Child Health Plan Plus comprehensive benefit package in areas where HMO services are not available, mainly rural areas. The self-insured managed care network provides the same benefit package through a managed care system that is provided through the HMOs in a managed care system.
Colorado's self-insured managed care network is a managed care delivery system. Most routine services are capitated. This network also utilizes medical management components such as referrals and prior-authorizations.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

The self- insured managed care network and the HMOs use managed care utilization standards to assure that enrollees only receive appropriate and medically necessary care. The standards/guidelines from the Department of Insurance regulations are as follows:

Utilization Review

1. Restricted as to the period of time in which the referring provider is authorized to perform services;
2. Open-ended with respect to time and scope, provided that a schedule for periodic review of medical necessity is established; or
3. Focused by provider referral type.

Utilization Management

1. Adequate controls are in place for preventing and/or monitoring unnecessary medical expenses associated with outpatient treatment.
2. Adequate controls are in place to ensure appropriate hospital admissions and length of

stays.
3. Appropriate professional resources are available to resolve difficult coverage and medical necessity issues, including procedures that may be considered experimental.
4. Utilization review procedures and protocols are updated and revised as appropriate, or at the States request.

Prescription Utilization Authorization and Review

The prescription utilization program has prior-authorization requirements for appropriate drugs, and monitoring and control of unnecessary utilization and abuse.

Case Management/Concurrent Review Services

1. Procedures for the identification and management of catastrophic cases. Because of the design of the program, many CHP+ eligible children with catastrophic or serious chronic conditions may be eligible for Supplemental Security Income (SSI), which would in turn make them eligible for Medicaid. The CHP+ network administrator ensures that the case management personnel have a thorough understanding of the SSI eligibility determination process, and ensures that appropriate referrals are promptly and efficiently made.
2. Criteria and procedures for prior approval of targeted and defined treatment plans, including defining which procedures require prior authorization.
3. Procedures and protocols for the prospective review of targeted clinical treatment plans submitted by network providers for inpatient and outpatient services. These procedures and protocols for clinical review shall include, but are not limited to:
    a. Procedures to ensure appropriate communication with network providers who may be involved in ordering or delivering such care;
    b. Procedures to ensure that all clinical reviews are conducted by personnel with appropriate clinical training and experience;
    c. Procedures to ensure that changes to treatment plans are approved and monitored appropriately.
4. Procedures to ensure that treatment plans requiring ongoing clinical review are approved and updated in a timely manner.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. X **Geographic area served by the Plan**: The plan is available statewide, in all 64 Colorado counties.

4.1.2. X **Age**: CHP+ is available to children 0 through 18 years of age.

4.1.3. X **Income**: To be eligible, a child must be from a family whose annual income is at or below 185% of the federal poverty level. Family size and income criteria are described in Attachment 2.

4.1.4. ~ **Resources** (including any standards relating to spend downs and disposition of resources): None

4.1.5. X **Residency (so long as residency requirement is not based on length of time in state):** Applicants must be Colorado residents. The state accepts self-declaration of Colorado residency. (See 4.1.9)

4.1.6. ~ **Disability Status** (so long as any standard relating to disability status does not restrict eligibility): No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because the child is eligible for Medicaid, not for reasons of disability status.

4.1.7. X **Access to or coverage under other health coverage**: Both the application and the separate "Insurance Form" ask families questions about other insurance coverage. The plan administration seeks information about all other access to health care coverage, both public and private, on the application form before the child is enrolled in the plan and from providers once the child is determined eligible for the plan. A child will be found ineligible if the child: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) is a member of a family that is eligible for health benefits coverage under a State health benefits plan based on a family members employment with a public agency in the State; or 4) has had coverage under an employer plan with at least a 50% employer contribution during the three months prior to application. The Health Care Program for Children with Special Needs is not considered a private health plan and children covered under this plan may still be covered by CHP+.

4.1.8. X **Duration of eligibility:** Once a child has been accepted, he or she is

continuously eligible for one year from the postmark date of the complete application unless the child moves from the state, turns 19 years old, or becomes enrolled in Medicaid, or other private insurance.

4.1.9. ~ Other standards (identify and describe): Colorado does not require social security numbers as a condition of eligibility for clients who are applying for the program.
Applicants must be 1) a U.S. citizen; or 2) a qualified alien, as defined in Public Law 104-193 as amended, who has been in the United States in a qualified alien status for at least five years or is not subject to the five-year bar set forth in section 403 of Public Law 104-193. The state accepts self-declaration of U.S. Citizenship.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. X These standards do not discriminate on the basis of diagnosis.
4.2.2. X Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. X These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Both initial eligibility and annual renewal eligibility for CHP+ are determined either at the main office or at a decentralized eligibility site.

All applications are received by mail or by Fax at the central office or during face-to-face interviews at the decentralized sites. Applications may also be dropped off in person during central office business hours.

The State has developed and implemented an eligibility, enrollment and application tracking system for CHP+. The system is designed to utilize a sophisticated business rules engine and state-of-the-art secure Internet technologies to reduce the overall cost of administration and increase the speed and accuracy of screening for Medicaid eligibility, determining eligibility for CHP+ and enrolling children into the program.

Current employment income, self-employment income and cash income from other sources reported is used to qualify families with employment or retirement income.

Verification of earned income must be provided if the applicant earned money during the previous month of the date of application. Earned income may be verified by current wage stubs, a note from an employer, a phone call to an employer (if permitted by applicant), or ledgers or receipts for self-employed applicants.

ELIGIBILITY DETERMINATION AND RENEWAL

Redetermination of Eligibility

Persons enrolled in CHP+ are enrolled for a period of twelve months. Renewal letters and packets are mailed to families at least 45 days before the day their CHP+ coverage terminates. Reminder letters are mailed to the family 30 days before the end-of-coverage date. Families are encouraged to return their completed renewal application at least 30 days prior to termination to allow continuity of care through their HMO. If the family does not resubmit a complete application by the ending date of coverage, the person's eligibility may still be renewed. The only penalty is interrupted coverage.

At redetermination, renewal requires the same financial documentation as was required at the time of the family's original application. A family will be fully processed for eligibility at each renewal period.

Enrollment in Health Plans

Applicants who live in areas served by HMOs must select a HMO to enroll in the CHP+. A family can select an HMO by indicating their HMO choice on the application form when they apply to the CHP+. When applications are received without an HMO selection, eligibility technicians attempt to contact the family to facilitate selection. If the technician cannot contact the family, the applicant is assigned an HMO and a letter is sent to the family. The family must either accept the assignment or make a different selection in order to be enrolled in CHP+. Families who live in areas of the state that are not served by an HMO will receive care through the CHP+ managed care network.

CHP+ applications include information on health plan service area. Applicants are instructed to select an HMO and are offered a 1-800 number to answer questions they may have. Enrolled persons receive services through the CHP+ managed care network until their HMO enrollment is effective. Enrollees can receive care through the CHP+ managed care network for a period of 14 to 45 days until the effective date of HMO coverage.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

X Check here if this section does not apply to your state.

The State does not currently have a waiting list. The State reserves the right to implement one if necessary and would do so in accordance with 42 CFR 457.65(d) including requesting a state plan amendment.

4.4. Describe the procedures that assure that:

Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

4.4.1 Medicaid Screening

The State has developed and implemented an eligibility, enrollment and application tracking system for CHP+. The system utilizes a sophisticated business rules engine and state-of-the-art secure Internet technologies to reduce the overall cost of administration and increase the speed and accuracy of screening for Medicaid eligibility, determining eligibility for CHP+ and enrolling children into the program.

Using the rules set, a precise determination of income for the Medicaid Budget Unit, including applicable income disregards, has been included to screen for Medicaid eligibility. Screening for Medicaid eligibility occurs at the time of application. For each child listed on the application, the system displays whether or not the child is eligible for Medicaid. The family of a child found to be eligible for Medicaid receives a letter indicating that the child cannot be insured by the plan because the child appears to be eligible for Medicaid. If the application originated at the CHP+ central office, the application is then forwarded to Medicaid Eligibility Technicians located at the central CHP+ administrative office; if the application originated at a satellite eligibility determination site, it is forwarded to the county department of social services and the family is given a 1-800-phone number to call with further questions. The family will be notified that the application will be reconsidered if Medicaid Technicians determine that the person is ineligible for Medicaid. CHP+ requests that the family provide the Medicaid denial letter.

Families who apply for Medicaid are informed about CHP+ and families applying for CHP+ are informed about Medicaid. The joint Medicaid/ CHP+ application notifies the applicant that information will be shared with both Medicaid and CHP+ to determine eligibility for both programs.

<u>Other Creditable Coverage Screening</u>

The joint Medicaid/CHP+ application, asks the applicant to report any health insurance coverage. If the family reports creditable coverage (most group health plans and health insurance coverage), the child will be found ineligible. Providers contracting with the CHP+ are required contractually to notify the plan whenever they have reason to believe a member has coverage other than CHP+. CHP+ then verifies coverage with the insurance carrier and notifies the family that they will be disenrolled.

If an applicant has received health insurance in the last three months and the employer paid more than 50% of the premium, there is a three month lock out period for the applicant.

State Employee Coverage

The joint Medicaid/CHP+ application asks if either parent has access to state health insurance. Children who have access to state employee coverage are not eligible for the CHP+ Program.

4.4.2 The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

CHP+ applicants are screened for Medicaid eligibility at the central site and decentralized sites. Medicaid-eligible person's applications are referred to county social service offices and Medicaid technicians housed in the CHP+ administrative offices. CHP+ eligibility staff follow up on these referrals with clients and notify eligibility staff that they have made a referral. Children who appear to be Medicaid eligible are only enrolled in CHP+ after they have received a denial letter from the State Medicaid staff. State Medicaid staff have access to important information concerning cases referred to Medicaid from CHP+ through the eligibility system. A 1-800 number is used to facilitate client questions concerning the disposition of their application that has been referred to Medicaid but originated with CHP+.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child care and Colorado Works. Many CHP+ referrals come from these programs. In addition, because federal law mandates linkage between CHP+ and Medicaid (for example, through a common application) about 20% of CHP+ applications are submitted through the Medicaid application process managed directly by county departments of

social services.

Colorado's joint Medicaid/CHP+ application allows families to complete a single application for both programs. This application facilitates referral processes. Medicaid eligibility determinations are conducted by the county departments of social services when applications for Medicaid are received at those locations. When an applicant is denied Medicaid for over income or over resources, the joint application is referred to the CHP+ central processor within 5 days. The applicant is sent a letter by the county department of social services notifying them that they have been denied for Medicaid and their application has been forwarded to CHP+. Upon receipt of the application, the applicant is processed for CHP+ eligibility.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. X Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The joint Medicaid/CHP+ application asks whether the applicant has been covered under an employer health benefits plan with at least a 50% employer contribution during the three months prior to application. A person is ineligible for the CHP+ if they have had such coverage in the noted time period, unless the coverage was terminated due to a loss of employment. The joint application also asks whether the applicant currently has group or individual coverage and will deem the person ineligible if he/she has such coverage.

Colorado will monitor for crowd-out. Reporting on a monthly basis occurs breaking out application denials due to other insurance and access to state employee benefits. CHP+ eligibility technicians can verify insurance information with the families' employers if necessary. If the results of monitoring indicate crowd-out is occurring, the state will develop and implement strategies to prevent it.

4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. If the state provides coverage under a premium assistance

program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

CHP+ has contracts with Indian Health Services in all areas of the state to allow tribal clinics to deliver health care to Native Americans. Because the federal legislation governing the Indian Health Services has regulations against the use of managed care, CHP+ pays these facilities fee-for-service. These primary care contracts, continue to allow Native Americans full access to specialty providers through a managed care environment (though still paid fee-for-service.)

CHP+ works directly with the Indian Health Resource Center to reach out to Native Americans living in the Denver metro area, home to nearly half of Colorado's Native Americans. CHP+ conducts outreach to Native Americans living in the remainder of the state, much of which is rural, through local public health nurses and caseworkers. In Southwestern Colorado, case workers at the San Juan Basin Health Department in Durango will provide outreach at two Indian Health Centers at the Ute Mountain Ute Indian Reservation near Towaoc and Southern Ute Indian Reservation in Ignacio.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the

programs, and to assist them in enrolling their children in such a program:
(Section 2102(c)(1)) (42CFR 457.90)

CHP+ created an extensive marketing and outreach program encompassing strategies that range from grass roots networking to mass market advertising campaigns. These efforts have been implemented to reach families many different ways with different messages**.**

To better evaluate the effectiveness of these strategies, CHP+ implemented a large-scale, application-source tracking system in March 2000. The system allows an application to be traced back to the initial source without relying on self-reported referral data. This tracking system will continue to be used to monitor trends and results from marketing and outreach campaigns.

1. Community Partnerships

A cornerstone of the CHP+ outreach strategy is to maintain and build on community partnerships. To reach all eligible families through as many avenues as possible, CHP+ works with more than 2000 partners. These include: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children nutrition programs; faith-based organizations and a myriad of others. So far, the most effective efforts in actually enrolling families are through schools, doctors' offices, health departments, community health centers, and departments of social services.

2. Hispanic-Related Partnerships:

In order to reach the substantial Hispanic population in Colorado, CHP+ partnered specifically with LARASA and the Mexican Consulate to explore appropriate avenues to reach this subpopulation. LARASA staffs a CHP+ advisory council that represents Hispanic business, faith-based and community service leaders. These community leaders advise CHP+ regarding the special needs of the Hispanic population.

3. Managed Care Organizations

Managed care organizations have increased their CHP+ outreach. One method of partnering has been the implementation of joint media campaigns in which a majority of managed care partners have participated. These purchased advertisements were structured so that each partner received air time when marketing would be most effective.

All of CHP+'s managed care partners have participated in various community events throughout the state.

4. Advertising and Earned Media

Television ranks as the highest source of referral for individual applications. CHP+ and managed care organizations team together to purchase targeted television advertisements.

5. County Departments of Social Services

County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child-care and Colorado Works. Many CHP+ referrals come from these programs. About 20% of CHP+ applications are submitted through the Medicaid application process managed by county departments of social services. CHP+ continues to focus on ways to minimize delays in referrals so that eligible children can be enrolled in an expeditious manner.

6. Satellite Eligibility Determination Sites

CHP+ has a network of 73 satellite eligibility determination sites (SED sites) statewide, including multiple locations for some sites. These sites comprise community health centers, county nursing services, school-based health centers, Indian Health Centers and other community providers, and have been an essential component of the programs outreach and enrollment activities. As part of their contract with CHP+, they are required to provide outreach to their community for CHP+ and have access to an on-line eligibility program to accelerate program enrollment. SED sites account for more than 30% of submitted applications.

7. Schools

Schools are consistently one of the most frequently cited sources of referral by applicants. Increasing numbers of school districts are partnering with CHP+ to assure the children they serve know about CHP+. In 2001, more than 60% of all school districts in the state participated in CHP+ outreach activities including coordination with National School Lunch Program information, disseminating materials about CHP+ to families or allowing CHP+ partners and staff to present to family-related functions.

8. Community Health Centers

The Colorado Community Health Network has made involving its members in Medicaid and CHP+ outreach a priority. Community health centers are the largest group of primary care providers throughout the state serving low-income children. Some serve as satellite eligibility determination sites. Others participate in community coalitions that enroll children in Medicaid and CHP+.

9. Covering Kids Colorado

A significant partner in developing community-based outreach has been Covering Kids Colorado, which is a Robert Wood Johnson Foundation funded grant program administered by the Department of Public Health and Environment. Colorado will be received a Covering Kids and Families Grant from the Robert Wood Johnson Foundation in 2002. This grant is administered by a coalition of community groups including the Colorado Community Health Network, the Colorado Children's Campaign and Catholic

Charities. The program focuses on three distinct communities, Denver City and County, the Mountain ski area counties of Eagle, Pitkin and Garfield, and Pueblo City and County**.**

10. Community Voices

This is a joint Kellogg Foundation and Colorado Trust funded program, which has among its goals to improve the health of Denver's medically underserved through innovations in community outreach, enrollment in publicly funded health insurance programs like CHP+, as well as small employment health plans, and clinical case management. Community Voices efforts are designed to demonstrate that culturally sensitive community outreach to underserved populations improves enrollment of eligible individuals into plans, while engaging and empowering communities to assume greater responsibility for health. Staff at the Department met regularly with the Denver Health and Hospital Corporations Community Voices team to explore program successes, as well as, identify and resolve issues that might impede enrollment and access to care.

11. Toll Free Number and Website

CHP+ maintains a toll free telephone number so that community partners, members and potential members can obtain information about the program. In addition, CHP+ maintains a website (www.cchp.org) that can be used as a reference tool for community partners, members and potential members. CHP+ has observed a steady increase in web-based traffic regarding the program over the past two years. Both the toll free telephone number and website have Spanish options. For other languages, CHP+ relies on AT&T' language line. This is publicized on program materials.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. X Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

6.1.4. Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. Coverage the same as Medicaid State plan

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. Coverage that is the same as defined by "existing

comprehensive state-based coverage

6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

See Attachment 3

6.2.1. X Inpatient services (Section 2110(a)(1))

6.2.2. X Outpatient services (Section 2110(a)(2))

6.2.3. X Physician services (Section 2110(a)(3))

6.2.4. X Surgical services (Section 2110(a)(4))

6.2.5. X Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. X Prescription drugs (Section 2110(a)(6))

6.2.7. Over-the-counter medications (Section 2110(a)(7))

6.2.8. X Laboratory and radiological services (Section 2110(a)(8))

6.2.9. X Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. X Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. X Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. X **Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)** **(Section 2110(a)(12))**

6.2.13. **Disposable medical supplies** **(Section 2110(a)(13))**

6.2.14. X **Home and community-based health care services (See instructions)** **(Section 2110(a)(14))**

6.2.15. **Nursing care services (See instructions)** **(Section 2110(a)(15))**

6.2.16. X **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest** **(Section 2110(a)(16)**

6.2.17. X **Dental services** **(Section 2110(a)(17))**

*Dental benefits were effective 2/1/02. Please see Attachment 5

6.2.18. **Inpatient substance abuse treatment services and residential substance abuse treatment services** **(Section 2110(a)(18))**

6.2.19. X **Outpatient substance abuse treatment services** **(Section 2110(a)(19))**

6.2.20. X **Case management services** **(Section 2110(a)(20))**

6.2.21. **Care coordination services** **(Section 2110(a)(21))**

6.2.22. X **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders** **(Section 2110(a)(22))**

6.2.23. X **Hospice care** **(Section 2110(a)(23))**

6.2.24. **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions)** **(Section 2110(a)(24))**

6.2.25. **Premiums for private health care insurance coverage** **(Section 2110(a)(25))**

6.2.26. X **Medical transportation** **(Section 2110(a)(26))**

6.2.27. **Enabling services (such as transportation, translation, and outreach services (See instructions)** **(Section 2110(a)(27))**

6.2.28. X **Any other health care services or items specified by the Secretary and not included under this section** **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. X The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a)):**

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330

of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. X Quality standards
7.1.2. X Performance measurement
7.1.3. X Information strategies
7.1.4. X Quality improvement strategies

CHP+ will use quality standards, performance measures, information strategies, and quality improvement studies to assure high-quality care for CHP+ enrollees. The CHP+ program will use quality assurance methods and tools such as NCQA accreditation standards, National Association of Insurance Commissioners (NAIC) standards, Quality Improvement System for Managed Care (QISMC), Healthplan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS) data, standard Division of Insurance reports and quality improvement study data. The CHP+ will use standards, performance measures, consumer information, and quality improvement methods for HMOs and for the CHP+ provider network.

The Department is in the process of negotiating a contract with a vendor to perform Quality Assurance activities. The Contractor will provide consulting services that incorporate Federal and State requirements that address ongoing quality assessment and improvement strategy for the Child Health Plan Plus Program (CHP+) contracting program. The strategy, among other things, will include:

- Physician credentialing in the self-insured managed care network
- Performance based contracting standards
- Self-insured managed care network HEDIS calculation audit
- HEDIS analysis for all plans

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and

childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))** The Department will contract with a quality assurance vendor to measure HEDIS indicators such as the following:

- Childhood Immunizations
- Adolescent Immunizations
- Children's access to primary care practitioners
- Appropriate medications for children with asthma
- Well child visits

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Adequate access to emergency services is assured for all Colorado managed care enrollees by a Division of Insurance regulation that took effect on July 1, 1997. This regulation (4-2-17) specifies that a managed care organization cannot deny an emergency claim if a "prudent lay person would have believed that an emergency medical condition or life or limb threatening emergency existed." The regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

The State's provider network administration contractor provides a plan to recruit, retain and educate providers contracted with the State program. This is a collaborative effort between the State and the provider network administration contractor. The plan includes, but is not limited to:

1) An analysis of the accessibility of providers contracted with the State, using the definitions of accessibility provided by the State;
2) Based upon the areas of need identified in the analysis, the Contractor recruits providers to participate in the CHP+ program and coordinates all recruitment activities with the managed care organizations contracted with the State to provide services through the program;
3) The Contractor conducts statewide provider site visits or other activities in consultation with the State, to train and update providers contracted to the State, regarding policies and CHP+ program enrollment and billing procedures.
4) The Contractor provides the State with an updated plan at least quarterly.
5) The State monitors access to covered services including emergency services through reports provided by the Contractor. As outlined in bullet number 1, the State defines appropriate access (ie 1 PCP to 2,400 enrollees). The Contractor is financially liable for failing to meet the requirements listed under 7.2.2.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with

chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollees medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Benefit procedures exist for members with chronic, complex, or serious medical conditions. All of the managed care organizations must comply with the Department of Insurance regulations regarding access to and adequacy of specialists.

The following are the benefits for persons with chronic conditions:

- Any combination of 30 treatment days for inpatient physical, occupational, and/or speech therapy per injury or illness. The services must be received within six months from the date on which the illness or injury occurred.
- Any combination of 30 treatments for outpatient physical, occupational, and/or speech therapy per illness or injury or diagnosed neurological, muscular, or structural abnormality per year.

State law requires that "In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers."

The DOI performs carrier audits, through Market Conduct Exams, that monitor, among other requirements, compliance with access to and adequacy of specialists. Carriers who do not comply with DOI regulations are subject to financial penalties imposed by the State. If a Managed Care Organization (MCO) is found to be out of compliance with DOI regulations, the State will require the MCO to submit a
Corrective action plan that includes adjusting any claims for enrollees affected by the regulation.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

The Child Health Plan Plus prior authorizations are consistent with commercial packages. The contracted managed care organizations and the self-insured network are required to comply with the State regulations set forth by the Division of Insurance. The state law is within the 14 day requirement.

Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. X YES
8.1.2. NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. **Annual Enrollment Fee:** For families above 151% of the Federal Poverty level it is: $25 for 1 child and $35 for two or more
8.2.2. **Deductibles**: None
8.2.2 **Copayments/coinsurance**: See Attachment 5

American Indian/Alaska Natives are exempt from co-payment and annual enrollment requirements.

8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b))

The Medical Services Board, a rule making body appointed by the Governor and confirmed by the Senate, was created by the Legislature effective July 1, 1994 with rule making authority for the Medicaid program. During the 2001 session, rule making authority was moved from the Children's Basic Health Plan Policy Board (which was disbanded) to the Medical Services Board. This new structure puts rule making authority in the same body for both the Medicaid and Children's Basic Health Plan, which increases the opportunity for streamlining and consolidation between programs. The Medical Services Board is subject to the regulations of the Administrative Procedures Act that provides direction to rule making boards throughout the state on public input around the rule making process.

Rules governing the CHP+ program are drafted and placed on the WEB and the public is

noticed regarding the hearing of the rules at the Medical Services Board meeting. The Medical Services Board hears testimony prior to passing rules. After rule adoption, the rules are published in the Colorado Registry and are placed on the WEB.

A chart describes coverage options, the cost sharing requirements for annual enrollment fees and specific services (copayments/coinsurance) based on income and family size, and the plans they can choose. A booklet designed specifically for a lower income audience describes how managed care plans work, and how to make a good choice for ones children.

Enrollees are notified of their exact cost sharing maximum based on their annual salary on their card that they receive upon enrollment. The member booklet also has a statement explaining the 5% maximum.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. X Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. X No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

The following procedures will be considered well-baby and well-child care: CPT-4 codes: Preventive medicine codes: 99381-New patient under one year; 99382-New Patient age 1-4 years; 99383-New patient ages 5-11 years; 99384-New patient ages 12 through 17 years; 99391-Established patient under one year; 99392-Established patient ages 1-4 years; 99393-Established patient ages 5 through 11 years; 99394 – Established patient aged 12-17; 99431- Newborn care (history and examination); 99432-Normal newborn care.

Evaluation and Management Codes: 99201-99205-New patient; 99211-99215-Established patient**.**

ICD-9-CM codes: V20-V20.2-Health supervision of infant and child; V70.0-General medical examination (routine); V70.3-V70.9-General medical examination.

All infants and children should be seen by a Primary Care Provider regularly for immunizations (shots) and check-ups. The CHP+ follows the well-child visits schedule recommended by the American Academy of Pediatrics. The American Academy of Pediatric recommends that children receive well-child visits at the following ages: 1 week, 1 month, 2 months, 4 months, 6 months, 9 months, 1

year, 15 months 18 months, 2 years, 3 years, 4 years, 5 years 6 years, 8 years, 10 years, 11 years, 12 years, and 13 years.

8.4.3 X No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Annual enrollment fees for families through 151% FPL will be waived. For families between 151% and 185%, the annual enrollment fee shall be $25 for one eligible child and $35 for two or more eligible children.

The 5% maximum allowable cost sharing limit is calculated for each individual family. The annual amount is then recorded on the family's enrollment card with instructions in the member packet of the "shoe box" method and the process to be followed when the limit is reached.

State planners feel that few families will reach their 5% limit. An analysis of the States fee schedule suggests that cumulative cost sharing will rarely exceed 1% of the family's adjusted gross income. However, CHP+ administrative personnel make families aware of the aggregate limit on cost sharing through a number of information and educational sources.

Through direct communication with families, the CHP+ marketing and outreach efforts often discuss the aggregate limit on cost sharing. The first direct written communication with CHP+ families instructs parents that the expenditures on their child(ren)s health care through CHP+ should not exceed 5% of family income. Through contracts with Managed Care Organizations, the CHP+ administration ensure that the plans make their enrollees aware of the aggregate limit on cost sharing by including information regarding the cost-sharing limit in their member handbooks.

The State has adopted the "shoe box" approach to reimburse families who exceed the 5% limit. Families are required to track expenditures based on he calculation of family income provided by the state and to submit receipts for all expenditures in excess of the 5% limit. Since the eligibility process will determine an "eligibility income" for each family, that family will receive notification of the exact dollar figure that will represent 5% of the family's adjusted gross income.

Once they submit evidence that they have exceeded the 5% cap, the state will issue them

a "co-pay exempt" sticker to be placed on their membership card. Providers and plans will be informed that enrollees with this sticker are not being charged copayment/coinsurance for any service. The 5% limit is calculated on the family's income at the time of eligibility determination. This cap is cited on the enrollment card. The cap will be recalculated if a family applies for a redetermination before the year is complete.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

The joint application includes a question asking the applicant to indicate their ethnicity. Alaskan Native and American Indian are two of the choices. When this information is entered into the computerized eligibility and tracking system. The rules engine recognizes ethnicity and determines a $0 copayment/coinsurance. This $0 is printed out on the enrollees' card. The provider uses this card to determine the copayment/coinsurance to be charged to the patient.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

If an enrollee does not pay the annual enrollment fee within 30 days after the notice, they are denied for the program. The state does not participate in collection action or impose benefit limitations if enrollees do not pay copayments/coinsurance.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

The enrollee is given 30 days to pay their enrollment fee in order to become enrolled in the program. If they do not pay the fee but appear to be eligible for Medicaid, the application date for Medicaid is the date of the receipt of the application at CHP+. The State does not disenroll for the lack of copay collection.

X The disenrollment process affords the enrollee an opportunity to show that the enrollees' family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**

X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. X No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. X No cost-sharing (including premiums, deductibles, copays, coinsurance **and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)***

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. X No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Strategic objectives are to:

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment.

2. Decrease the proportion of children in Colorado who are uninsured.

3. Encourage employer based coverage.

4.Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.

5. Improve access to dental care for children.

9.2 Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment.

Performance Goals:

- Contract with a Quality Assurance vendor by October 2002.
- Develop measurable performance goals with the Quality Improvement committee by January 2003.
- The CHP+ Quality Improvement Committee will choose up to seven health measures focused on children and perform an administrative measurement of the health status of our population to serve as a baseline.
- Baseline will be administrative, to include up to seven HEDIS ® measures for CY 2002
- Once the baseline has been determined, the QI Committee will decide what areas can be positively impacted. Interventions will be determined and implemented to improve the status of the CHP+ population (Children) CY 2003.

2. Decrease the proportion of children in Colorado who are uninsured.

Performance Goals:

- By FY 04-05 the Department is to have an enrollment rate of 85% of the estimated eligible population every year.
- Improve uninsured estimates statewide by November 1, 2002.
- Collect enrollment Statistics on a quarterly basis.

3. Encourage employer based coverage.

Performance Goals:

- Maintain the three month lock out period for those applicants having had employer paid health insurance (employer paying at least 50%) within three months of application.
- Continue to ask if the applicant has other insurance on the joint application.
- Undertake a study of best practices in marketing and will identify through this study groups that are under represented. This will be accomplished by May 2003.
- Develop a strategy for target marketing after the analysis of the above mentioned study.

4.Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.

Performance Goals:

- Evaluate the transfer process of cases to State Medicaid Technicians at the administrative offices in FY 03-04.
- Conduct an analysis of claims data to identify groups of children in the Medicaid and CHP+ programs that have similar utilization and cost patterns in order to determine the feasibility of combining CHP+ and Medicaid children into a seamless benefit structure.

5. Improve access to dental care for children.

Performance Goals:

- The University of Colorado Dental School, in cooperation with the Department, will conduct a survey to study the utilization patterns of dental services of CHP+ members. The survey will also include a customer service portion and provider satisfaction. This will be conducted by May 2003.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

The Plan shall be measured through performance indicators identified by the Quality Improvement Committee and vendor.

Check the applicable suggested performance measurements listed below that the

state plans to use: (Section 2107(a)(4))

9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. X The reduction in the percentage of uninsured children.
9.3.3. The increase in the percentage of children with a usual source of care.
9.3.4. X The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. X HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. Other child appropriate measurement set. List or describe the set used.
9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
- 9.3.7.2. Well child care
- 9.3.7.3. Adolescent well visits
- 9.3.7.4. Satisfaction with care
- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. Other, please list:

9.3.8. Performance measures for special targeted populations.

9.4. X The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. X The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

Colorado's S-CHIP estimated baseline of uncovered, low-income children is 172,457, with a CHP+ eligibles baseline estimate of 69,157. This is a revision since the estimate submitted to HCFA in the 1998 annual report. The Department felt the availability of more recent data, specific to Colorado, provided opportunity to derive an estimate that would more closely reflect the current status of children in the state.

Colorado's S-CHIP began with year 2000 population projections for children under age 19 for each county in the state. The source of these projections was the Colorado Demography Information Service within the Colorado Division of Local Government. Then, using individual county uninsured rates (published in the 1997 Colorado Health Source Book: Insurance, Access, and Expenditures, April 1998, and funded by the Rose Community Foundation and The Colorado Trust), each county's population projection was multiplied by its uninsured rate to get the number of uninsured under age 19 in that county. The Colorado Health Source Book derived the method for determining its uninsured rates from "Estimating County Percentages of Uninsured People," Inquiry, 28:413-419 (1991),

and used a three-year average of 1995-1996-1997 CPS data from the March Supplements. County uninsured rates ranged from 9.0% to 40.9% among the 63 counties in Colorado, varying widely from the overall state estimate of 15.2%. The computed county estimates of uninsured under age 19 were summed to get a total for the state. The following tables summarize this methodology:

Number of Children Who Are Uninsured

	Colorado 1997 County Uninsured rates (Colorado Demography Information Service)	**2000 Colorado Population under Age 19**	**# of Uninsured under Age 19 (Sum of County Estimates)**
Uninsured under 19	Range = 9.0% - 40.9%	1,145,447	172,457

This represents all uninsured children in the state, at all income levels. To determine the number of children who would be S-CHIP-eligible, or at or below 185% of the federal poverty level (FPL), The Department used an estimate from the American Academy of Pediatrics (AAP) which says that S-CHIP-eligibles under 200% FPL in the state comprise 40.1% of the uninsured under age 19. The source for this estimate was AAP's analysis of 1994-1997 March Current Population Survey Supplements and a 1998 Census Bureau child population projection. Each county's under-19 uninsured estimate was multiplied by this percentage to get S-CHIP eligibles by county, which were then summed to get a state total. (If 40.1% is applied to the state total number of uninsured under age 19, instead of each county's total, a slightly different estimate is obtained, but the difference is negligible, attributable to the rounding of county estimates.)

Number of Uninsured Children Who Are S-CHIP-Eligible:

	AAP CHIP-Eligible Percentage (Using 1994-1997 CPS and Census 1998 projection)	**Number of Uninsured under Age 19**	**2000 Colorado Population under Age 19, Uninsured, and under 200% FPL**
Uninsured under age 19	40.1%	172,457	69,157

It is this final estimate -- 69,157 -- against which Colorado's S-CHIP measures its performance in reducing the proportion of uncovered, low-income children in the state, for FFY 1998 and FFY 1999.

The State assures that it will submit the evaluation required under Section 10 by January 1st of each year. The State also assures that it will complete an annual assessment of the progress made in reducing the number of uncovered low-income children, and report to the Secretary on the result of the assessment.

The assessments will be based largely upon the strategic objectives se forth in Section 9 and

program evaluation criteria designed by the evaluation consultant. The strategic objectives focus on enrolling children, establishing usual sources of care, measuring enrollee and provider satisfaction, and improving health status. The data used to measure performance will be compiled from existing databases. In addition, child-relevant HEDIS measures are being used to assess the quality of care provided to SCHIP children.

9.6. X The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. X The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. **(Section 2107(d))**

Attachment 4

9.8.1. X Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. X Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. X Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

Six working teams were created to design the core elements of the CHP+ and to promote ongoing public input into the plan. The CHP+ teams recommended benefits and cost sharing were applied to the CHP+ proposed in this Title XXI State Plan. The six teams were: 1) benefits design and pricing; 2) eligibility, enrollment, and management information system design; 3) financing; 4) marketing and outreach; 5) employer advisory group; and 6) contracting and quality assurance. A Policy Board reviewed team recommendations and gave strategic direction to the Department of Health Care Policy and Financing. The individuals who were members of these working teams

had the opportunity to provide input into the development of CHP+, from the early stages of the decision-making process up to and beyond implementation. These working teams were staffed and led by individuals representing the Department, the business community, the insurance industry, providers, children's advocates, schools, employers, and other public and private programs providing services to children.

Benefits Design and Pricing. This team was responsible for designing the benefit package and developing cost-sharing and subsidy structures. This team developed price estimates for the benefit package under different cost sharing and subsidy structures scenarios. Members of this team represented advocates for low-income families, the Colorado Division of Insurance, mental health providers, EPSDT outreach workers, providers of care to handicapped children, pediatricians, community health centers, and managed care organizations.

Marketing and Outreach. This team was responsible for developing a marketing plan and outreach strategy for partnering with schools, doctors offices, employers, social service providers, and public health entities throughout the state. This team recommended to the Department the most effective outreach plan, materials design, and marketing strategy to ensure that eligible families are notified that this product was available and how they could apply. The team developed a long term, phased plan for outreach and marketing CHP+. Not only school systems were tapped, but team members, through their varied work in the community were natural advocates and enlisted volunteers who could advocate for CHP+, throughout the state. Members of this team represented schools, day care centers, managed care organizations, providers, children's advocacy groups, and the Colorado Child Health Plan (CCHP).

Eligibility, Enrollment, and Management Information Systems Design. This team was responsible for developing an eligibility and enrollment system that would be flexible, simple to administer, and meet the long-term needs of CHP+. This team was also responsible for developing recommendations for the rules by which a child would be deemed eligible for the program. Members of this team included representatives from managed care organizations, the Medicaid program in the Department of Health Care Policy and Financing, the Program for Children with Special Health Care Needs, Indian tribes, community health centers, the Colorado Child Health Plan, philanthropic provider clinics, and other providers.

Financing. This team was responsible for identifying funding streams available to finance the program, preparing budget projections, developing estimates of the number of children that would be enrolled, and creating mechanisms to ensure that CHP+ would be fiscally sound. Members of this team included representatives from community health centers, the Colorado Indigent Care Program, the Office of State Planning and Budgeting, the Colorado Child Health Plan, and the Department of Health Care Policy and Financings budget and accounting offices.

Employer Advisory Group. This team presented recommendations to the Department regarding mechanisms to ensure that CHP+ did not become a substitute for employer-based coverage. This group established a means for the Department and employers to coordinate coverage for children eligible for the program, create incentives for employers to assist the Department with outreach and eligibility determination, and presented recommendations as to how the subsidy can be

structured to ensure that employees did not drop employer-based coverage. Membership of this team represented a broad base of employers and business organizations such as US West, Kodak, and Mile Hi Child Care Centers.

Contracting and Quality Assurance: This team was responsible for developing purchasing strategies and contract standards for the CHP+ program. The team reviewed options for purchasing, pricing and quality assurance from Medicaid and commercial models.

Policy Board: The initial Department-appointed Policy Board reviewed key team recommendations and gave strategic guidance to the Department of Health Care Policy and Financing in the design and implementation of CHP+. This group was comprised of high-level private sector business managers, hospitals, providers, children's advocates, the insurance industry, the General Assembly, the Colorado Department of Public Health and Environment, and the Colorado Division of Insurance.

The Department-appointed Policy Board disbanded after the passage of House Bill 98-1325, which became law on April 21, 1998. A provision of that legislation created an 11-member Policy Board charged with promulgating rules for the as CHP+.

Upon dissolution of the Policy Board in August 2001, the Department of Health Care Policy and Financing must propose rules (regulations) to the Medical Services Board. The Medical Services Board, a rule making body appointed by the Governor and confirmed by the Senate, was created by the Legislature effective July 1, 1994 with rule making authority for the Medicaid program. During the 2001 session, rule-making authority was moved from the Children's Basic Health Plan Policy Board (which was disbanded) to the Medical Services Board. This new structure puts rule-making authority in the same body for both the Medicaid and Children's Basic Health Plan, which increases the opportunity for streamlining and consolidation between programs. The Medical Services Board is subject to the Administrative Procedures Act (state statute) that provides direction to rule making boards throughout the state on public input around the rule making process. The public is able to attend Board meetings and testify on any rule being presented. This allows the Board to hear any and all concerns that advocates across the state may have about a new or revised rule.

Public input is also received through a variety of other methods:

- Department staff meet regularly with patient advocacy groups;
- Drafts of items requesting public input are placed on the CHP+ Website;
- Any member of the public has the right to correspond directly with Board members.

9.9.1 **Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))**

CHP+ contracts with Indian Health Services providers as SED sites. We receive valuable information from local tribes from the organizations that serve the local American Indian tribes around the barriers to providing health insurance to this population. Because the Indian Health Services provides routine health care services to this population, it is difficult to demonstrate the need for health insurance. We are constantly looking for ways to market to this population.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

A special committee was created as a part of the Policy Board to study dental provider adequacy. This committee represented advocacy groups, dental providers, State Health Department staff and Board members.
The rules were presented to the State Medical Assistance Advisory Council and staff brought their recommendation to add language requiring the inclusion of Essential Community Providers to the Policy Board in the dental network was accepted.

A dental benefit was added effective February 1, 2002. Prior to the effective date, the Children's Basic Health Plan Policy Board and the State Medical Assistance and Services Advisory Council forums were used as mechanisms for public notice and input. The State Medical Assistance and Services Advisory Council is a group with specialized knowledge and experience to be added to that available in the Department of Health Care Policy & Financing, and provides a two-way channel of communication with the individuals, organizations, and institutions in the community that, with the administrating Agency, provide and/or pay for medical care and services.

Once the rules were adopted, they were published on the Child Health Plan Plus Web site. All adopted rules are also sent to the Secretary of State and published in the Colorado Code of Regulations.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

Planned use of funds, including --

- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child

and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

See Budget Attachment 4

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. X The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. X The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. X The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 **X** The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. X 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. X Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. X Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. X Section 1128A (relating to civil monetary penalties)
- 11.2.5. X Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. X Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

Every applicant or enrollee has the opportunity to review the denial of eligibility, the failure to make a timely determination of eligibility or the termination of enrollment. If an applicant does not agree with the eligibility determination assessed by the contractor, the applicant may appeal the decision. This appeal must be in writing and within 30 days of the eligibility determination letter. If the appeal cannot be favorably resolved with the contractor, the appeal is taken to the Grievance Committee. The Grievance Committee consists of the appeal staff person from the contractor, an eligibility technician, and three staff persons from the Department of Health Care Policy and Financing that are impartial in accordance with 42 CFR 457.1150. The three staff persons have never seen the case before and are well versed in the rules of the program. Applicants may attend the committee meeting by telephone, in person, or may send a representative and may have access to all documents that were used to determine their eligibility. All communication needs are taken care of for the applicant during a committee meeting; i.e. translation. A final decision is made during the Grievance Committee meeting and the applicant is notified of the decision in writing within 10 days. This assures compliance with 42 CFR 457.1140. All decisions made in the Grievance Committee are final.

If there is an immediate need for health services, the appeal is expedited through the appeals coordinator. An emergency meeting of the Grievance Committee is held in order to review the case within 2 working days to assure quality of care. The entire process is consistent with 42 CFR 457.1180 and a decision would be made within 2 working days.

Cost Sharing is not an issue, however, during the appeal process, the renewing applicant remains on the program until the Grievance Committee makes a decision and is not disenrolled. This assures compliance with 42 CFR 457.1140(d)(2), (3) and (4).

Colorado does not disenroll for failure to pay cost sharing.

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

Health Services Matters

Within the MCO contracts are provisions regarding health services matters. The Contractor is to agree to adequately staff and maintain a Member services and Complaint response function to explain operations, assist in the selection of a PCP, assist in how to make appointments and recording and responding to member complaints, or oral expressions of dissatisfaction with the Contractors plan.

The Contractor shall process prospective, concurrent and retrospective reviews, and have in place procedures for complaints and appeals of Adverse Determinations that comply with the requirements concerning these activities contained in Title 10, C.R.S., and Colorado Division of Insurance regulations. All determinations of Medical Necessity of Covered Services are subject to these appeal processes.

Division of Insurance Regulation 4-2-17 requires that health carriers have an Internal Review Process consisting of First and Second Level Appeal Review of Adverse Determination. In the First Level Review process, the appeal shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. In the Second Level Review process, a carrier must appoint a grievance review panel with a minimum of three (3) people. The panel may be composed of employees of the health carrier who have appropriate professional expertise.

Once an individual has exhausted the Internal Review process described above, Division of Insurance regulation 4-2-21 allows the individual to have the adverse determination reviewed by an independent external review entity. The Division of Insurance Commissioner shall approve which independent external review entity will be assigned to conduct the review.

Division of Insurance regulation 6-2-1 requires all carriers to maintain a prescribed complaint record log.

The State assures that the Division of Insurance regulations 4-2-17, 4-2-21, and 6-2-1 are consistent with the intent of 42 CFR 457,1130(b). The State's Self-Insured Managed Care Network follows all of the Department of Insurance regulations.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR §457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Attachment 1:
Colorado Children by Income, Race/Ethnicity, and Health Insurance Coverage Status

Children in Colorado Age 0 through 5 by Income and Coverage Status

% FPL	0-41%	42-100%	101-133%	134-185%	186-200%	201-250%	251+%	Row Totals
Medicare	36	35	42	0	0	0	0	**113**
Employer-based and Medicaid	491	1,279	717	602	424	0	73	**3,586**
Employer-based	4,841	7,612	7,428	40,230	2,122	40,574	87,912	**200,719**
Medicaid	25,052	32,078	5,463	7,335	629	905	1,393	**72,855**
Private, Nongroup	0	2,547	0	3,401	0	2,990	14,841	**23,779**
Uninsured	1,735	13,691	8,636	11,181	880	6,635	8,921	**51,679**
Column Totals	**32,155**	**57,242**	**22,286**	**62,749**	**4,055**	**51,104**	**123,140**	**352,731**

Source: RAND Corporation Survey funded by the Robert Wood Johnson Foundation, 1993

Children in Colorado Age 6 through 14 by Income and Coverage Status

% FPL	0-41%	42-100%	101-133%	134-185%	186-200%	201-250%	251+%	Row Totals
Medicare	42	1,714	366	0	0	0	0	**2,122**
Employer-based and Medicaid	0	879	37	0	0	0	184	**1,100**
Employer-based	1,222	9,887	13,824	39,696	8,546	48,197	220,833	**342,205**

Medicaid	21,057	22,166	1,664	2,722	0	423	1,934	**49,966**
Private, Nongroup	0	6,197	0	6,428	0	6,929	26,753	**46,307**
Uninsured	4,864	19,252	13,161	16,425	1,597	13,637	12,516	**81,452**
Column Totals	27,185	60,095	29,052	65,271	10,143	69,186	262,220	**523,152**

Source: RAND Corporation Survey funded by the Robert Wood Johnson Foundation, 1993

Children in Colorado Age 15 through 18 by Income and Coverage Status								
% FPL	**0-41%**	**42-100%**	**101-133%**	**134-185%**	**186-200%**	**201-250%**	**251+%**	**Row Totals**
Medicare	36	0	0	0	0	0	0	**36**
Employer-based and Medicaid	0	457	366	0	0	0	0	**823**
Employer-based	325	5,998	8,199	7,739	1,911	20,786	89,096	**134,054**
Medicaid	2,561	3,734	1,407	187	0	0	906	**8,794**
Private, Nongroup	462	0	0	2,077	0	2,176	11,032	**15,747**
Uninsured	4,408	4,686	2,914	6,132	247	3,977	5,871	**28,235**
Column Totals	**7,792**	**14,875**	**12,886**	**16,135**	**2,158**	**26,939**	**106,905**	**187,690**

Source: RAND Corporation Survey funded by the Robert Wood Johnson Foundation, 1993

Children in Colorado Age 0 through 18 by Race / Ethnicity and Coverage Status							
	White	**Black**	**Hispanic**	**Native American**	**Alaska Native**	**Asian Pacific**	**Row Totals**

						Islander	
Medicare	479	36	1,756	0	0	0	
Employer-based and Medicaid	2,217	0	3,256	0	0	35	
Employer-based	553,143	27,397	79,173	1,842	0	15,422	
Medicaid	65,357	8,100	54,934	2,772	96	357	
Private, Non-group	71,946	0	4,757	4,279	0	4,851	
Uninsured	100,524	6,816	50,989	1,880	48	1,09	
Column Totals	**793,667**	**4,248**	**194,865**	**10,773**	**144**	**21,773**	

Source: RAND Corporation Survey funded by the Robert Wood Johnson Foundation, 1993

Attachment 2

CHILD HEALTH PLAN *PLUS*

2002 ABILITY-TO-PAY SCALE

Effective April 1, 2002

Income Ranges for Each Ability-to-Pay Rate

Family Size	N	A	B	C	D	E	F	F+
1	0 – 3,544	3,545– 5,493	5,494 – 7,177	7,178 – 8,860	8,861- 10,366	10,367 – 11,784	11,785 – 13,290	13,291 – 14.
2	0 – 4,776	4,777 – 7,403	7,404 – 9,671	9,672 - 11,940	11,941 –13,970	13,971-15,880	15,881 – 17,910	17,911 – 18.
3	0 – 6,008	6,009 – 9,312	9,313-12,166	12,167-15,020	15,021-17,573	17,574-19,977	19,978 – 22,530	22,531 – 23.
4	0 – 7,240	7,241–11,222	11,223-14,661	14,662-18,100	18,101-21,177	21,178-24,073	24,074 – 27,150	27,151 – 28.
5	0 – 8,472	8,473-13,132	12,133-17,156	17.157-21,180	21,181-24,781	24,782-28,169	28,170 – 31,770	31,771 – 33.
6	0 – 9,704	9,705-15,041	15,042-19,651	19,652-24,260	24,261-28,384	28,385-32,266	32,267 – 36,390	36,391 – 38.
7	0 – 10,936	10,937-16,951	16,952-22,145	22,146-27,340	27,341-31,988	31,989-36,362	36,363 – 41,010	41.011 – 43.
8	0–12,168	12,169–18,860	18,861–24,640	24,641-30,420	30,421-35,591	35592-40,459	40,460 – 45,630	45,631 48,3
9	0 – 13,400	13,401– 20,770	20,771- 27,135	27,136- 33,500	33,501- 39,195	33,196- 44,555	44,556- 50,250	50,251- 53,
10	0 – 14,632	14,633– 22,680	22,681- 29,630	29,631- 36,580	36,581- 42,799	42,800- 48,651	47,575- 54,870	54,871- 58,
Poverty Level*	40%	62%	81%	100%	117%	133%	150%	159%

*** Percent of federal poverty level that corresponds to the upper limit of income in each rating level.**

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Revised 03/12/01apicmic

Attachment 3

Benefit Package Description

	DESCRIPTION OF BENEFIT
EMERGENCY CARE AND URGENT/AFTER HOURS CARE	Covered.
EMERGENCY TRANSPORT/AMBULANCE SERVICES	Covered.
Hospital/Other Facility Services A. INPATIENT B. PHYSICIAN C. OUTPATIENT/ AMBULATORY	Covered.
ROUTINE MEDICAL OFFICE VISIT 1	Covered.
LABORATORY AND X-RAY	Covered.
PREVENTIVE, ROUTINE, AND FAMILY PLANNING SERVICES	Covered. Same benefits as mandated under the Small Group Standard Health Benefit Pl Division of Insurance Regulation 4-6-5 (e.g. immunizations, well-child visits and health visits.)
MATERNITY CARE Prenatal Delivery & inpatient well baby care2	 Covered. Covered. State law requires infant to be covered for first 31 days.
MENTAL ILLNESS CARE A. NEUROBIOLOGICALLY-BASED MENTAL ILLNESSES3 B. ALL OTHER4 1. INPATIENT5 2. OUTPATIENT	 Covered. Treated the same as any other health condition (e.g. there are no limits on the hospital days covered.) Limited coverage. 45 days of inpatient coverage with the option of converting 45 inpa days of day treatment services. Limited coverage. 20 visit limit.
ALCOHOL AND SUBSTANCE ABUSE	Limited coverage. 20-outpatient visit limit. Inpatient is not covered except for acute det days per episode.
PHYSICAL THERAPY, SPEECH THERAPY, AND OCCUPATIONAL THERAPY	Limited coverage. 30 visits per diagnosis per year.

1 Routine medical office visits includes physician, mid-level practitioner and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.
2 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.
3 Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.
4 All other mental health benefits include coverage for all mental health conditions recognized in the DSM-IV manual.
5 The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

	DESCRIPTION OF BENEFIT
DURABLE MEDICAL EQUIPMENT (DME)6	Limited coverage. Maximum $2,000/year paid by plan. Coverage for lesser of purchas price for medically necessary durable medical equipment, including home administered
TRANSPLANTS	Limited coverage. Will include those transplants covered by the Small Group Standard Division of Insurance regulation 4-6-5), including liver, heart, heart/lung, lung, cornea, kidney/pancreas, and bone marrow for Hodgkin's disease, aplastic anemia, leukemia, in disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and W syndrome only. Peripheral stem cell support is a covered benefit for the same condition for bone marrow transplants. Transplants will be covered only if they are Medically Ne facility meets clinical standards for the procedure. Coverage is no less extensive than th any other physical illness.
HOME HEALTH CARE	Covered.
HOSPICE CARE7	Covered.
PRESCRIPTION DRUGS	Covered. (includes expendable medical supplies for the treatment of diabetes)
KIDNEY DIALYSIS	Covered, only when Member is not eligible for Medicare.
SKILLED NURSING FACILITY CARE	Coverage for medically necessary skilled nursing facility care only. Benefits will not be custodial care or maintenance care or when maximum medical improvement is achieved significant measurable improvement can be anticipated.
VISION SERVICES	Limited coverage. Vision screenings are covered as age appropriate preventive care. $5 for eyeglasses.
AUDIOLOGY SERVICES	Limited coverage. Hearing screenings are covered as age appropriate preventive care. H covered for congenital and traumatic injury; maximum $800/year paid by plan.
INTRACTABLE PAIN	Covered. Included as a benefit with the medical office visit copay.
AUTISM COVERAGE	Covered. Included as a benefit with the medical office visit copay.
CASE MANAGEMENT	Covered, when Medically Necessary.
DIETARY COUNSELING /NUTRITIONAL SERVICES	Limited coverage. Formula for metabolic disorders, total parenteral nutrition, enterals a products, and formulas for gastrostemy tubes are covered for people with documented n Documentation includes prior authorization, which lists medical condition including gas disorders, malabsorption syndromes or a condition that affects normal growth patterns o absorption of nutrition.
LIFETIME MAXIMUM	Not applicable.
DENTAL RELATED	Medical coverage in connection with treatment of the teeth or periodontium is excluded treatment: is performed by a physician or legally licensed dentist, is begun within 72 ho accidental injury to sound natural teeth. Orthodontic and prosthodontic treatment for cl palate is included for newborns. Regular and routine dental services are provided through a dental contractor. These ser diagnostic, preventative, and restorative services with a maximum allowable benefit of $

6 DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devises applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the member is **not** covered.

7 Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Division of Insurance Regulation 4-2-8 as amended.

	DESCRIPTION OF BENEFIT
PRE-EXISTING CONDITION LIMITATIONS	No pre-existing condition limitations.
THERAPIES: CHEMOTHERAPY AND RADIATION	Covered. When received during a covered admission and billed as part of the facility se charges will be paid in the same manner as room expenses and other ancillary services. shall not be interpreted as an exclusion of Chemotherapy and Radiation therapy when d outpatient setting.
EXCLUSIONS	Benefits covered by a no-fault auto policy or employers liability laws; care that is not m necessary; cosmetic surgery; custodial care; educational training programs; experimenta investigational procedures; learning disorders; marital or social counseling; nursing hon specifically otherwise covered under this plan; sexual dysfunction, infertility treatment except as specifically otherwise covered under this plan; TMJ with no medical basis; tre related illnesses and injuries except for those individuals who are not required to mainta by workers' compensation insurance as defined by workers' compensation laws8; trans those listed above; dental related services except for those listed above; and war.

8 Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries.

Attachment 4

Colorado Child Health Plan Plus - Budget

Federal Fiscal Year 2003

	Federal Fiscal Year First Year Costs
Enhanced FMAP rate	65%
Benefit Costs	
Insurance payments	0
Managed care	43,640,264
per member/per month rate @ # 48,132	75.09
Fee for Service	0
Total Benefit Costs	**43,640,264**
(Offsetting beneficiary cost sharing payments)	268,966
Net Benefit Costs	43,371,298
Administration Costs	
Personnel	494,715
General administration	443,751
Contractors/Brokers (e.g., enrollment contractors)	725,242
Claims Processing	0
Outreach/marketing costs	0
Other (CBMS and HIPAA)	1,535,212
Total Administration Costs	3,198,920
10% Administrative Cost Ceiling	$4,819,033
Federal Share (multiplied by enh-FMAP rate)	$30,270,642
State Share	$16,299,576
TOTAL PROGRAM COSTS	$46,570,218

Notes: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.
Source of State funds - General Fund and Tobacco Litigation Settlement Funds
Total Program Costs = Net Benefit Costs + Total Administration Costs.
Due to rounding, $43,371,298 /$75.09/12 is slightly higher than the 48,132 represented above.

Attachment 5

CHP+ Cost-Sharing

Poverty Level	Family size: 2 people	3 people	4 people	5 people	6 people	7 people	8 people	Annual Enrollment Fee		Copayment
	Annual Income							One Child	2 or more children	Outpatient Serv
1% - 100%	Up through $11,060	Up through $13,880	Up through $16,700	Up through $19,520	Up through $22,340	Up through $25,160	Up through $27,980	No Enrollment Fee	No Enrollment Fee	No Copay
101% - 150%	$11,061 - $16,590	$13,881 - $20,820	$16,701 - $25,050	$19,521 - $29,280	$22,341 - $33,510	$25,161 - $37,740	$27,981 - $41,970	No Enrollment Fee	No Enrollment Fee	$2
151% - 185%	$16,591 - $18,802	$20,821 - $23,596	$25,051 - $28,390	$29,281 - $33,184	$33,511 - $37,978	$37,741 - $42,772	$41,971 - $47,566	$25	$35 two or more children	$5

Actuarial Report
Child Health Plan Plus
October 1997

Background

This actuarial report was developed at the request of the Colorado Department of Health Care Policy and Financing by *Leif Associates, Inc.*, an independent actuarial consulting firm. The purpose of the report is to supplement the State of Colorado's application for Federal funds under Title XXI of the Social Security Act for the Child Health Plan Plus. Title XXI, Section 2103, specifies that the scope of health insurance coverage under this program must consist of either benchmark coverage, benchmark-equivalent coverage, existing comprehensive state-based coverage, or Secretary-approved coverage. Certain actuarial values must be set forth in an actuarial opinion in an actuarial report to accompany the State's application. Those actuarial values include the following:

- The actuarial value of the coverage provided by the benchmark benefit packages;
- The actuarial value of the coverage offered under the State child health plan;
- The actuarial value of the coverage of any categories of additional services under benchmark benefit packages; and,
- The actuarial value of any categories of additional services under coverage offered by the State child health plan.

This actuarial report includes the actuarial values listed above, along with supporting documentation and other information.

Benchmark Benefit Packages

The benchmark benefit packages identified in Title XXI, Section 2103, are as follows:

- **FEHBP-equivalent children's health insurance coverage**. This is described as the standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

  The Blue Cross/Blue Shield preferred provider option service benefit plan is composed of an in-network benefit and an out-of-network benefit package. As stated in FEHBP documentation, the non-PPO benefits are the standard benefits of the plan. PPO benefits apply only when the covered person uses a PPO provider. Therefore, the non-PPO benefits of the FEHBP plan were used in this study to determine the actuarial value of FEHBP coverage.

- **State employee coverage**. This is described as a health benefits coverage plan that is offered and generally available to State employees in the State involved.

  The State of Colorado currently offers five HMO and three self-funded health benefit plans for its employees to choose from. The plan that currently has the largest enrollment is known as the Exclusive Path. This plan covers approximately 15,000 State employees and their dependents, out of a total of approximately 28,000 State employees that are covered under the State's employee health benefit plans. The Exclusive Path uses a large network of health care providers, and coverage is provided only when care is secured from those providers. It has the typical plan design features of an HMO plan. For purposes of this study, the Exclusive Path was chosen as the benchmark state employee benefit coverage.

- **Coverage offered through an HMO.** This is described as the health insurance coverage plan that:

  (A) is offered by a health maintenance organization (as defined in section 2791 (b)(3) of the Public Health Service Act), and
  (B) has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

In order to determine the HMO benchmark coverage for Colorado, an informal survey of the largest HMOs in the state was conducted by the Colorado Department of Health Care Policy and Financing. Based on this informal survey, it was determined that the HMO plan that has the largest insured commercial, non-Medicaid enrollment of covered lives in Colorado is the Kaiser Foundation Health Plan of Colorado Plan 710, with pharmacy, durable medical equipment, and optical riders. This plan was used as the benchmark HMO coverage for purposes of this study.

A plan design grid, which shows the details of the benefits of these three benchmark plans, is attached to this report and labeled as Exhibit I.

Child Health Plan Plus Benefit Packages

The benefit structure for the Child Health Plan Plus will vary depending on whether HMO plans are available. The fee-for-service program will be available in areas where no HMO coverage is available.

The proposed HMO Child Health Plan Plus includes two separate benchmark-equivalent benefit packages. One is for children in families between 100% and 150% of the Federal poverty level. The other is for children in families between 150% and 185% of the Federal poverty level. The plans each provide coverage for the same health care services. The only difference between the two plans is the level of cost sharing. Copayments, when required, will be higher for participants with family incomes between 150% and 185% of the Federal poverty level than for participants with family incomes between 100% and 150% of the Federal poverty level.

A plan design grid, which shows the details of all three Child Health Plan Plus benefit packages, is attached to this report and labeled as Exhibit II. The coverage includes benefits for items and services within each of the categories of basic services described in Section 2103.

Methodology for Determining Actuarial Equivalency

In order to determine the actuarial equivalency of the proposed Child Health Plan Plus benefit packages to the benchmark plans, the following methodology was used.

- **Identification of a standardized set of utilization and price factors**.

  The standardized set of utilization and price factors used to determine the actuarial equivalency of the Child Health Plan Plus to the benchmark plans is set forth in Exhibit III of this report. These standardized utilization and price factors have the following characteristics:

1. The factors were based on a compilation of data from a number of unpublished sources;

2. The factors were adjusted to reflect weighted statewide Colorado health care utilization and costs, rather than those for a specific geographic location within Colorado;

3. The factors represent the unique health care utilization and cost patterns for children, rather than adults or the combination of children and adults;

4. The factors were developed for children at various ages and weighted using the standardized population of children described below to arrive at combined average factors for children under nineteen years of age;

5. The factors were projected to mid-year 1998, using typical utilization and cost trends;

6. The factors were based on typical insured coverage utilization and costs in a traditional fee-for-service environment with limited utilization management;

7. The development of the factors involved considerable actuarial judgement.

- **Identification of a standardized population.**

  The standardized population used to determine the actuarial equivalency of the Child Health Plan Plus to the benchmark plans is set forth in Exhibit IV of this report. This standardized population is the projected 1997 Colorado population by single age for children ages 0 through 18, as determined by the U.S. Bureau of the Census, Population Projections Branch. This standardized population is believed to be representative of the

distribution of privately insured children of the age of children who are expected to be covered under the State child health plan.

- **Calculation of the actuarial value of the benchmark plans and the categories of additional services included in the benchmark plans**.

  Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the three benchmark benefit plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below.

	FEHBP Coverage	*State Employee Coverage*	*HMO Coverage*
Aggregate Actuarial Value	$ 74.35	$ 81.81	$ 82.71
Additional Services Actuarial Value			
Prescription Drugs	$ 4.21	$ 4.53	$ 6.11
Mental Health Services	$ 6.39	$ 6.50	$ 6.54
Vision Services	$ -0-	$ 0.70	$ 0.92
Hearing Services	$ -0-	$ 0.29	$ 0.19

In calculating the actuarial values stated above, the same actuarial principles and standardized factors were used in comparing the value of different coverage and categories of services, without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

- **Calculation of the actuarial value of the Colorado plans and the categories of additional services included in the Colorado plans**.

  Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the proposed Colorado plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below.

	Fee-For-Service Plan	*HMO Plans*	
		Between 100% and 150% FPL	*Between 150% and 185% FPL*
Aggregate Actuarial Value	$ 87.91	$ 98.43	$ 96.69

Additional Services Actuarial Value			
Prescription Drugs	$ 6.67	$ 6.86	$ 6.22
Mental Health Services	$ 6.63	$ 6.63	$ 6.60
Vision Services	$ 1.04	$ 1.04	$ 1.00
Hearing Services	$ .65	$ 0.65	$ 0.65

In calculating the actuarial values stated above, the same actuarial principles and standardized factors were used in comparing the value of different coverage and categories of services, without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

The cost sharing reflected in the benefit structure for participants below 150% of Federal poverty level meets the requirements stated in Section 2103 (e) (3). The copayments for participants between 150% and 185% of Federal poverty level are minimal, and when combined with the proposed premium payments for the program, are not expected to result in cost sharing that exceeds 5% of family income. Therefore, it is expected that the actuarial values shown above will not be increased because of cost sharing limitations which might otherwise result in an increase in the actuarial value of the plans.

It is important to recognize that the actuarial values developed from the standardized utilization and cost factors in this report do not represent the actual expected costs of the Child Health Plan Plus. The program is expected to include significant utilization management and negotiated provider reimbursements through the implementation of HMO contracts. It is also expected that the age distribution of children enrolled in the plan will not mirror that of privately insured children, as reflected in the Colorado population projections. Assumptions regarding the cost impact of managed care approaches and the actual expected enrollment distribution are not included in this report.

- **Determination of actuarial equivalence of the Colorado plans to the benchmark plans.**

  The proposed Child Health Plan Plus benefit packages have an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages. The actuarial value of these benefit packages exceeds the actuarial value of all three benchmark benefit packages.

  With respect to each of the categories of additional services described in Section 2103, the proposed Child Health Plan Plus benefit packages have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in the benchmark packages. The actuarial value of these additional services exceeds the actuarial value of the corresponding additional service in each of the three benefit plans. A summary table is shown below.

	Benchmark Plans			*Colorado Plans*		
	FEHBP Coverage	*State Employee Coverage*	*HMO Coverage*	*Fee-For-Service Plans*	*HMO 100% to 150% FPL*	*HMO 150% to 185% FPL*

Aggregate Actuarial Value	$ 74.35	$ 81.81	$ 82.71	$ 87.91	$ 98.43	$ 96.69
Additional Services Actuarial Value						
Prescription Drugs	$ 4.21	$ 4.53	$ 6.11	$ 6.67	$ 6.86	$ 6.22
Mental Health Services	$ 6.39	$ 6.50	$ 6.54	$ 6.63	$ 6.63	$ 6.60
Vision Services	$ -0-	$ 0.70	$ 0.92	$ 1.04	$ 1.04	$ 1.00
Hearing Services	$ -0-	$ 0.29	$ 0.19	$ 0.65	$ 0.65	$ .65

Report Preparation

Elizabeth J. Leif, Consulting Actuary and President of Leif Associates, Inc., a private actuarial consulting firm, prepared this actuarial report. Ms. Leif is a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a member of the American Academy of Actuaries.

Actuarial Opinion

I, Elizabeth J. Leif, a member of the American Academy of Actuaries, have performed the actuarial calculations described in this report and prepared the report and supporting documentation. It is my opinion that:

- The report has been prepared using generally accepted actuarial principles and methodologies;
- The report has been prepared in accordance with the principles and standards of the Actuarial Standards Board for such reports;
- A standardized set of utilization and price factors has been used;
- A standardized population that is representative of privately insured children of the age of children who are expected to be covered under the Child Health Plan Plus has been used;
- The same principles and factors have been applied in comparing the value of different coverage (or categories of services);
- Differences in coverage based on the method of delivery or means of cost control or utilization used have not been taken into account;
- The ability of the State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the Child Health Plan Plus that results from the limitations on cost sharing under such coverage has been taken into account.

Elizabeth J. Leif, FSA
Consulting Actuary
Leif Associates, Inc.
707 Seventeenth Street, Suite 2900
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October 10, 1997

Exhibit 1 - Child Health Plan Plus
Benchmark Benefit Packages

Benefit Category	1997 FEHBP - Standard BCBS PPO Plan		1997 Colorado State Employee Coverage - Exclusive Path	HMO Plan - Kaiser Permanente Plan 710
	PPO	Non-PPO[1]		
ANNUAL DEDUCTIBLE Individual Family	$200 per person[2] $400 per family		None	None
COINSURANCE	95%	75%	100%	100%
OUT-OF-POCKET MAXIMUM Individual Family	$2,000 $2,000	$3,750 $3,750	None	None
HOSPITAL AND EMERGENCY ROOM TRANSPORT	After $200 calendar year deductible, plan pays 75% of the allowable charge		Up to a $500 maximum benefit for ground ambulance; up to a $4,000 maximum benefit for air ambulance	No charge
INPATIENT	$250 deductible per admission;[3]		$150 copay per admission	Paid in full
	100% coinsurance after per admission deductible	70% coinsurance after per admission deductible		
INPATIENT PHYSICIAN CARE	95% coinsurance after the $200 calendar year deductible	75% coinsurance after the $200 calendar year deductible	Paid in full	Paid in full
OUTPATIENT FACILITY CARE	After $200 calendar year deductible, plan pays in full, subject to $25 (PPO) or $100 (Member facility) copayment per facility per day	After $200 calendar year deductible, plan pays in full, subject to $150 copayment per facility per day	$75 copay per emergency room visit; $25 copay per physician emergency room visit	$10 copay each visit; $50 copay for emergency services received inside the service area from non-plan providers
OUTPATIENT SURGERY	Plan pays in full, subject to $25 (PPO) or $100 (Member facility) copayment	Plan pays in full, subject to $150 copayment	$10 copay per visit	$10 copay per visit
ACCIDENTAL INJURY	Plan pays 100% of covered charges within 72 hours after accidental injury for hospital outpatient care		Paid same as illness	Paid same as illness

MEDICAL OFFICE OR HOME VISIT	$10 copayment for each outpatient office visit charge	75% coinsurance after the $200 calendar year deductible	$10 copay per visit	$10 copay per visit
LABORATORY & X-RAY SERVICES	Covered at outpatient facility care rates for X-ray, laboratory, pathological services, and machine diagnostic tests		Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	After the $200 calendar year deductible, plan pays 95% (PPO) or 75% (PAR or non-participating physician)		$10 copay per visit	$10 copay per visit
PREVENTIVE CARE	Paid at outpatient facility care rates for cervical cancer screening, mammogram for breast cancer screening, fecal occult blood test for colorectal cancer screening, PSA for prostate cancer screening, tetanus-diphtheria booster, and immunization for influenza and pneumonia		$5 copay for certain services;[4] no payment required for routine mammograms according to age-specific guidelines or prostate screening	Immunizations medically indicated and consistent with accepted medical practice are provided without charge
WELL CHILD CARE	For children up to age 22, plan pays 100% of the allowable charge for all healthy newborn inpatient physician visits, and routine physical exams, lab tests, immunizations, and related office visits as recommended by the American Academy of Pediatrics		$5 copay for certain services	$10 copay per visit
MATERNITY CARE Prenatal Delivery & inpatient well baby care	Plan pays in full Pays in full for unlimited days with no per admission deductible (PPO hospital) or after $250 per admission deductible (Member hospital)	After the $200 calendar year deductible, plan pays 75% After the $250 per admission deductible, plan pays 70%	$10 copay per office visit $150 copay per admission	$10 copay per office visit No charge
INFERTILITY DIAGNOSIS AND TREATMENT	95% coinsurance after the $200 calendar year deductible	75% coinsurance after the $200 calendar year deductible	$10 copay per office visit; covered up to $2,500 per calendar year[5]	Medical services are provided with $10 copay per visit. Artificial insemination is covered, except for donor semen, donor eggs, and services related to procurement and storage. All other services related to conception by artificial means, prescription drugs related to such services are not covered.[6] Infertility drugs covered with a 50% charge

ABORTION	Benefits will not be paid for procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest		Covered only if there is a medical condition that threatens the mother's life if the pregnancy continues, a lethal medical condition in the unborn child that would cause the death of the unborn child during pregnancy or at birth, or a psychiatric condition that may seriously threaten the mother's life if the pregnancy continues to term	
ALL OTHER MENTAL HEALTH Inpatient care	After a $150 (PPO) or $250 (Member hospital) copayment, plan pays the remainder up to 100 days	After a $400 per day copayment, plan pays the remainder of the cost up to 100 days	$150 copayment, then 100% up to 45 days per calendar year	1 - 20 days, no charge; 21 - 45 days, 50%
Inpatient physician visits	After the $200 calendar year deductible, plan pays 60% of the allowable charge			No charge
Outpatient facility care	After the $200 calendar year deductible, plan pays in full, subject to $25 (PPO) or $100 (Member facility) copayment	After the $200 calendar year deductible, plan pays in full, subject to $150 copayment		
Professional care	After the $200 calendar year deductible, plan pays 60% of the allowable charge; limited to 25 visits per person per calendar year		$10 copayment per visit, then 100%	1 - 10 visits, $10 each visit; 11 or more visits, $25 each visit
ALCOHOL & SUBSTANCE ABUSE	Inpatient: one treatment program (28-day maximum) per person per lifetime; covered at the same levels as hospital care and inpatient visits for mental conditions; outpatient also subject to the same levels as mental conditions		Same as mental health	Inpatient detoxification: same as other hospitalization. Inpatient rehab: only evaluation and referral are covered. Outpatient: 50% covered up to $650 per 12 month period
ORGAN TRANSPLANTS	After the $200 calendar year deductible, plan pays 95% (PPO) or 75% (PAR or non-participating) • Allogeneic bone marrow[7] • Autologous bone marrow and autologous peripheral stem cell support[8]		100% of covered expenses, including organ procurement and acquisition.[11] Kidney and cornea require a $10 copay per office visit and a $150 per admission hospital copay	Covered transplants are: • Kidney • Heart

	• Allogeneic bone marrow and allogeneic peripheral stem cell support for multiple myeloma and autologous bone marrow and autologous peripheral stem cell support[9] • Single or double lung transplants for end-stage pulmonary diseases[10] • Cornea • Kidney • Heart • Liver • Heart-lung • Pancreas	• Heart • Heart-lung • Kidney-pancreas • Pancreas • Liver • Bone marrow (allogeneic and autologous)[12] • Peripheral blood stem cell • Kidney • Cornea Travel expenses for transportation, lodging and meal expenses at 100% up to a total maximum of $10,000 for a child transplant recipient[13]	• Heart-lung • Liver • Lung • Cornea • Kidney/pancreas • Bone marrow transplants associated with high dose chemotherapy for germ cell tumors and neuro-blastoma in children are covered. • Bone marrow transplants associated with high dose chemotherapy for other solid tissue tumors are not covered
DURABLE MEDICAL EQUIPMENT	After $200 calendar year deductible, plan pays 75% for rental or purchase of durable medical equipment, wheelchairs, hospital beds, crutches, orthopedic braces, prosthetic appliances, and one bra per person per calendar year for use with an external breast prosthesis	Covered at 100%, no annual maximum; includes artificial arms, legs, or eyes, leg braces, arm and back braces, maxillofacial prosthesis, cervical collars, surgical implants, oxygen and equipment needed to administer it, and insulin pumps and related supplies	Covered with 20% copayment, including oxygen and orthotic and prosthetic devices
PHYSICAL AND OCCUPATIONAL THERAPY	After $200 calendar year deductible, plan pays 75% up to 50 visits for physical therapy and 25 visits for occupational and speech therapy per person per calendar year	$10 copay per visit for independent therapists; no payment required for hospital outpatient therapy	$10 copay per visit, up to 2 months per condition, or up to 30 visits per condition if not received within 2 months
HOME HEALTH CARE	After the $200 calendar year deductible, plan pays 75% for home nursing care for up to 2 hours per day up to 25 visits per calendar year	Paid at 100%, up to 60 visits per year	No charge
HOSPICE CARE Home	Plan pays in full for member with life expectancy of six months or less for physician visits, nursing care, medical social services, physical therapy, services of home health aides, durable medical equipment rental, prescription drugs, and medical supplies	Paid at 100%, $8,100 benefit payment limit during a 3-month period. Paid at no less than $91 per day	No charge

Hospital Bereavement Support	Up to 5 consecutive days if receiving home hospice care; must be separated by at least 21 days and is paid in full with no (PPO) or $250 (Non-member hospital) per admission deductible Not covered		Paid at 100%, after $150 per admission copayment, up to 30 days Up to $1,053 per family per calendar year	No charge No charge
OUTPATIENT PRESCRIPTION DRUGS	$50 per person annual deductible, then 80% coinsurance; $100 family annual deductible; $12 per prescription copay for mail service prescription drug program[14]	$50 per person annual deductible, then 60% coinsurance; $100 family annual deductible	$10 generic, $15 brand name plus cost difference between brand and generic if generic is available and not prescribed "dispense as written." $10 per brand name if no generic equivalent exists	$5 copay per prescription for up to a 60-day supply.
CONTRACEPTIVE DEVICES AND DRUGS	• IUDs, Norplant, Depo-Provera, and oral contraceptives obtained from a physician are covered at 95% or 75% after $200 deductible • IUDs, Norplant, Depo-Provera, and oral contraceptives dispensed by a retail pharmacy are covered as prescription drugs • Oral contraceptives are also covered under the mail service prescription drug program		The plan covers oral contraceptives, birth control shots, and certain contraceptive devices and their insertion. Does not cover Norplant device and related expenses	Oral contraceptives are covered. Norplant is covered at a charge of $200, with no refund if the drug is removed. Contraceptive devices are provided at reasonable charges
SKILLED NURSING FACILITY CARE	When Medicare Part A is primary, plan provides secondary benefits for Medicare Part A copayment incurred in full during the 1st through 30th day		Not covered	No charge up to 100 days per calendar year
VISION SERVICES	After $200 deductible, plan pays 75% for one set of eyeglasses or contact lenses required as a result of a single instance of intra-ocular surgery or injury		Routine eye exams covered at 100% after a $5 office copayment, once every 24 months. No allowance for lenses/ frames. One set of prescription eyeglasses or contact lenses are covered when needed to replace human lenses absent at birth or lost through intra-ocular surgery or eye injury or for treatment for keratoconus	$10 copay per visit for eye exams for glasses; each 24 months, one pair of lenses, frames up to $65, contact lenses up to $100
HEARING SERVICES			Hearing exams paid at 100%, after a $5 copayment. Up to $500 hearing aid allowance once every 3 years	Hearing exams covered with $10 copay per visit
DENTISTRY	Oral and maxillofacial surgery, limited to listed procedures.[15] Plan pays 75% after $200 calendar d d ibl f i li li		Covered only if treated in a hospital or other facility i h i i	Coverage <u>is not</u> provided for dental care and x-rays, d l i f ll i

	for accidental injury to sound natural teeth; scheduled amount for other dental care	outpatient basis for certain conditions.[16] Benefits based on surgery benefits	accidental injury to teeth, dental appliances, orthodontia, and dental services associated with medical treatment. Coverage is provided for medically necessary services for the treatment of cleft lip or palate for newborn members, unless the member is covered for these services under a dental insurance policy
LIFETIME MAXIMUM	Only for smoking cessation and substance abuse	None	None
SMOKING CESSATION TREATMENT PROGRAM	$100 per person per lifetime for one program	Not covered	Covered with a reasonable charge
EXCLUSIONS	• If no charge would be made if individual had no health insurance coverage • Furnished without charge • While in active military service • Sustained as result of act of war or during combat • Furnished by immediate relatives or household members • Furnished by provider barred from FEHBP program • Furnished by a non-covered facility, except that medically necessary prescription drugs are covered • For or related to sex transformation, sexual dysfunction, or sexual inadequacy • Not specifically listed as covered • Experimental or investigational, except for the clinical trials benefit • Not provided in accordance with accepted professional medical standards in the U.S. • Any portion of fee that has been waived • Charges the enrollee or plan has no legal	• Biofeedback • Custodial care • Maintenance care • Any care that is not preauthorized • Hypnosis or hypnotherapy treatment • Any treatment that is not medically necessary • Treatments considered experimental and/or investigational and/or unproven • Treatment of nicotine or caffeine addiction • Services and related expenses for i h l	• Workers Comp or employer responsibility • Custodial or intermediate level care • Cosmetic services • Dental services and X-rays including services following accidental injury to teeth or surgery on the jaw • Physical exams for employment or insurance • Experimental or investigational services • Services not generally and customarily available • Sex transformations • Routine foot

	obligation to pay • In the case of inpatient care, medical services which are not medically necessary • Standby physicians • Biofeedback and other forms of self-care or self-help training, including cardiac rehab • Orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures • Custodial care • Services and supplies furnished or billed by an extended care facility, nursing home, or other non-covered facility, except as specifically described • Eyeglasses, contact lenses, routine eye exams or vision testing for the prescribing or fitting of eyeglasses or contact lenses • Eye exercises, visual training, or orthoptics, except for non-surgical treatment of amblyopia and strabismus • Hearing aids or examinations for the prescribing or fitting of hearing aids • Treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures • Personal comfort items such as beauty and barber services, radio, television, or telephone • Services or supplies for cosmetic purposes • Routine services, except for those preventive services specifically identified • Routine foot care • Recreational or educational therapy • Assisted Reproductive Technology procedures, such as artificial insemination, in vitro fertilization, embryo transfer, and GIFT	program • Nutritional supplements • Acupuncture • Genetic counseling • Norplant device and related expenses • Rehabilitation for learning disorders, stuttering, short- and long-term memory therapy, or behavior modification • Cognitive therapy services. • Personal comfort and convenience items • Cosmetic surgery • Sex-change operations • Sterilization reversal • Radial keratotomy • Attention deficit disorder • Biofeedback • Chiropractic services • Hair loss • Private duty	medically necessary • Chiropractic services • Services for members confined in criminal justice institutions • Refractive eye surgery • Long-term rehabilitation • Pulmonary rehabilitation • Food products for enteral feedings • Directed blood donations • Reversal of voluntary, surgically induced infertility

	• Services rendered by non-covered providers such as chiropractors, except in medically under-served areas • Procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered or result of rape or incest • Inpatient private duty nursing • Radial keratotomy • Reversal of surgical sterilization • Marital, family, educational, or other counseling or training services	nursing • Skilled nursing facilities • Workers' Comp	

[1]The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
[2]Calendar year deductible applies to all covered services and supplies except for certain inpatient hospital benefits, facility benefits - outpatient surgery, additional benefits, prescription drug benefits, and dental benefits.
[3]Must be precertified; benefits will be reduced by $500 if emergency admission is not precertified within two business days following the day of admission;
[4]Immunizations as recommended by American Academies of Pediatrics and Family Physicians, routine gynecological exams twice each year, age-specific routine physical examinations, and routine vision examinations.
[5]Covers artificial insemination in vivo. Does not cover any cost associated with donor sperm or any other service, supply, or drug used with or for an artificially induced pregnancy, such as "test tube" fertilization, drug-induced ovulation, or other artificial means of conception.
[6]Does not cover in vitro fertilization, ovum transplants, gamete intrafallopian transfer, and zygote intrafallopian transfer.
[7]For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Wiskott-Aldrich syndrome, mucopolysaccharidosis, mucolipidosis, severe or very severe aplastic anemia, advanced forms of myelodysplastic syndromes, and thalassemia major.
[8]For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors, and multiple myeloma.
[9]For breast cancer and epithelial ovarian cancer, only when performed as part of a clinical trial that meets the requirements and is conducted at a cancer research facility.
10Pulmonary fibrosis, primary pulmonary hypertension, and emphysema; double lung transplant for end-stage cystic fibrosis.

[11]Does not cover solid organ transplant in patients with an existing or recent malignancy, excluding hepatomas less than 5 cm in diameter, or patients with carcinoma.
[12]Does not cover bone marrow transplantation (allogeneic and autologous) for melanomas, colon cancers, AIDS, certain brain tumors, testicular cancer, sarcomas, lung cancer, ovarian cancer, and peripheral neuroepithelioma. Does not cover autologous bone marrow transplant and peripheral blood stem cell transplant for chronic myelogenous leukemia, multiple myeloma, or brain metastases.
[13]Covers expenses incurred by both the child transplant recipient and up to two adults accompanying the transplant recipient.
[14]Drugs obtained through the mail service prescription drug program are not subject to any deductible.
[15]Excision of tumors and cysts, surgery needed to correct accidental injuries, excision of exostoses of jaws and hard palate, external incision and drainage of cellulitis, incision and surgical treatment of accessory sinuses, salivary glands or ducts, reduction of dislocations and excision of temporomandibular joints, and removal of impacted teeth.
[16]Excision of exostoses of the jaw, surgical correction of accidental injuries, incision and drainage of cellulitis, incision of accessory sinuses, salivary glands, or ducts, tumors of the jaw, accident-related dental expenses, orthognathic surgery when required because of a malocclusion of the jaw, and TMJ-related services up to $1,000 per calendar year.

Exhibit II - Child Health Plan Plus
Colorado Benefit Plans

Benefit Category	Fee-For-Service Plan	HMO Plan Families < 150% FPL	HMO Plan Families > 150% FPL
ANNUAL DEDUCTIBLE Individual			None

Family	None	None	
COINSURANCE	100%	100%	100%
OUT-OF-POCKET MAXIMUM Individual Family	None	None	None
HOSPITAL EMERGENCY ROOM AND EMERGENCY TRANSPORT (COMBINED)	$15 copay emergency room; emergency transport not covered	$15 copay, waived if admitted	$15 copay, waived if admitted
INPATIENT	Paid in full	Paid in full	Paid in full
INPATIENT PHYSICIAN CARE	Paid in full	Paid in full	Paid in full
OUTPATIENT FACILITY CARE	Paid in full	Paid in full	Paid in full
OUTPATIENT SURGERY	Paid in full	Paid in full	Paid in full
ACCIDENTAL INJURY	Paid same as illness	Paid same as illness	Paid same as illness
MEDICAL OFFICE OR HOME VISIT	$2 copay per visit	$2 copay per visit	$5 copay per visit
LABORATORY & X-RAY SERVICES	Paid in full	Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	$2 copay per visit	$2 copay per visit	$5 copay per visit
PREVENTIVE CARE	Paid in full	Paid in full	Paid in full
WELL CHILD CARE	Paid in full	Paid in full	Paid in full
MATERNITY CARE Prenatal Delivery & inpatient well baby care	Paid in full Paid in full	Paid in full Paid in full	Paid in full Paid in full
INFERTILITY DIAGNOSIS AND TREATMENT	$2 copay per visit	$2 copay per visit	$5 copay per visit

ABORTION	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest
ALL OTHER MENTAL HEALTH Inpatient care Outpatient care	 Paid in full up to 45 days per calendar year $2 copay, 20 visit limit	 Paid in full up to 45 days per calendar year $2 copay, 20 visit limit	 Paid in full up to 45 days per calendar year $5 copay, 20 visit limit
ALCOHOL & SUBSTANCE ABUSE	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered
ORGAN TRANSPLANTS	Not covered	Covered transplants are: • Liver • Heart • Heart/lung • Cornea • Kidney • Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome • Peripheral stem cell support for same conditions	Covered transplants are: • Liver • Heart • Heart/lung • Cornea • Kidney • Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome • Peripheral stem cell support for same conditions
DURABLE MEDICAL EQUIPMENT	Paid in full up to $2,000 per year	Paid in full up to $2,000 per year	Paid in full up to $2,000 per year
PHYSICAL AND	$2 30 i i	$2 30 i i	$5 30 i i

OCCUPATIONAL THERAPY	year	year	year
HOME HEALTH CARE	No charge	No charge	No charge
HOSPICE CARE	Not covered	Paid in full	Paid in full
OUTPATIENT PRESCRIPTION DRUGS	$2 copay per prescription	$1 copay per prescription	$3 generic, $5 brand name copay per prescription
CONTRACEPTIVE DEVICES AND DRUGS	Covered	Covered	Covered
SKILLED NURSING FACILITY CARE	Not covered	Paid in full	Paid in full
VISION SERVICES	$2 copay per visit, $50 annual benefit for eyeglasses	$2 copay per visit, $50 annual benefit for eyeglasses	$5 copay per visit, $50 annual benefit for eyeglasses
HEARING SERVICES	Paid in full, up to $800 per year	Paid in full, up to $800 per year	Paid in full, up to $800 per year
DENTISTRY	Not covered	$2 copay for preventive services	$5 copay for preventive services
LIFETIME MAXIMUM	None	None	None
EXCLUSIONS	• Experimental procedures • Custodial care • Personal comfort items • TMJ treatment • Treatment for obesity • Acupuncture • Biofeedback • In vitro fertilization • Gamete or zygote intrafallopian transfer • Artificial insemination • Reversal of voluntary sterilization	• Experimental procedures • Custodial care • Personal comfort items • TMJ treatment • Treatment for obesity • Acupuncture • Biofeedback • In vitro fertilization • Gamete or zygote intrafallopian transfer • Artificial insemination • Reversal of voluntary sterilization	• Experimental procedures • Custodial care • Personal comfort items • TMJ treatment • Treatment for obesity • Acupuncture • Biofeedback • In vitro fertilization • Gamete or zygote intrafallopian transfer • Artificial insemination • Reversal of voluntary sterilization • T l

	sterilization • Transsexual surgery • Treatment of sexual disorders • Cosmetic surgery • Radial keratotomy • Biofeedback • Chiropractic services • Private duty nursing • Workers' Comp • Physical exams for employment or insurance • Routine foot care not medically necessary • Services for members confined in criminal justice institutions • Any treatment not medically necessary • Dental care • Hospice care • Transplants • Emergency transport • Skilled nursing facility • Autism	sterilization • Transsexual surgery • Treatment of sexual disorders • Cosmetic surgery • Radial keratotomy • Biofeedback • Chiropractic services • Private duty nursing • Workers' Comp • Physical exams for employment or insurance • Routine foot care not medically necessary • Services for members confined in criminal justice institutions • Any treatment not medically necessary	surgery • Treatment of sexual disorders • Cosmetic surgery • Radial keratotomy • Biofeedback • Chiropractic services • Private duty nursing • Workers' Comp • Physical exams for employment or insurance • Routine foot care not medically necessary • Services for members confined in criminal justice institutions • Any treatment not medically necessary

Exhibit III - Child Health Plan Plus

Standardized Utilization and Cost Factors									
		Standardized Utilization				Standardized Cost			
		0 - 1	2 - 6	7 - 18	Combined	0 - 1	2 - 6	7 - 18	Combined
Categories of Basic Services									
Inpatient Hospital									
	Medical/Surgical	0.6480	0.0795	0.0835	0.1384	$ 2,618.59	$ 1,962.05	$ 2,125.73	$ 2,131.97
	Maternity	0.0000	0.0000	0.0012	0.0007	$ 1,661.22	$ 1,661.22	$ 1,661.22	$ 1,661.22
Outpatient Hospital									
	Emergency Room	0.1705	0.1840	0.1915	0.1875	$ 285.08	$ 285.08	$ 285.08	$ 285.08
	Surgery	0.0409	0.0428	0.0279	0.0331	$ 2,346.81	$ 2,346.81	$ 2,346.81	$ 2,346.81
	Other	0.0000	0.3891	0.1089	0.1711	$ 176.73	$ 176.73	$ 176.73	$ 176.73
Physician									
	Inpatient Surgery	0.0459	0.0094	0.0136	0.0157	$ 1,229.10	$ 1,662.66	$ 1,735.79	$ 1,666.62
	Outpatient Surgery	0.1501	0.1328	0.1831	0.1668	$ 390.91	$ 373.60	$ 235.15	$ 286.57
	Office Visits and Misc.	5.8634	3.1907	1.8037	2.5662	$ 59.74	$ 58.26	$ 61.28	$ 60.34
	Hospital Visits	0.5235	0.0595	0.1578	0.1685	$ 179.78	$ 153.18	$ 141.88	$ 148.57
	Emergency Room Visits	0.1744	0.1620	0.1486	0.1547	$ 125.65	$ 115.90	$ 101.22	$ 107.45
	Maternity Care	0.0000	0.0000	0.0004	0.0003	$ 2,919.51	$ 2,919.51	$ 2,919.51	$ 2,919.51
	Other	0.1329	0.0177	0.0154	0.0276	$ 165.73	$ 163.84	$ 167.56	$ 166.41
Laboratory and X-Ray Services									
	Radiology/Pathology Facility Services	0.1323	0.0813	0.0951	0.0952	$ 376.90	$ 376.90	$ 376.90	$ 376.90
	Radiology/Pathology Physician Services	1.7186	1.2825	1.1491	1.2401	$ 33.26	$ 37.34	$ 40.27	$ 38.81
Well Child Services									
	Immunizations	2.9311	1.0148	0.2033	0.6843	$ 32.55	$ 32.55	$ 32.55	$ 32.55
	Well Baby Exams	3.2099	0.0000	0.0000	0.3178	$ 68.55	$ 6.46	$ 68.55	$ 52.41
	Well Child Exams	0.0000	0.1021	0.1500	0.1227	$ -	$ 99.58	$ 149.34	$ 121.62

Categories of Additional Services									
Prescription Drugs		4.1778	2.8195	1.6975	2.2347	$ 24.33	$ 31.00	$ 42.66	$ 37.81
Mental Health Services									
	Inpatient	0.0000	0.0035	0.0730	0.0477	$ 1,339.47	$ 1,339.47	$ 1,339.47	$ 1,339.47
	Outpatient	0.0000	0.0644	0.2070	0.1494	$ 128.50	$ 128.50	$ 128.50	$ 128.50
Vision Services									
	Vision Exams	0.0248	0.0754	0.1766	0.1353	$ 74.35	$ 74.35	$ 74.35	$ 74.35
	Glasses/Contacts	0.0000	0.0285	0.0699	0.0522	$ 213.37	$ 213.37	$ 213.37	$ 213.37
Hearing Services									
	Hearing Exams	0.0018	0.1003	0.0322	0.0469	$ 57.59	$ 57.59	$ 57.59	$ 57.59
	Hearing Aids	0.0000	0.0070	0.0070	0.0063	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00
Other Categories of Services									
	Substance Abuse Inpatient	0.0000	0.0000	0.0206	0.0132	$ 980.60	$ 980.48	$ 980.48	$ 980.49
	Substance Abuse Outpatient	0.0000	0.0000	0.0064	0.0041	$ 113.40	$ 113.40	$ 113.40	$ 113.40
	Skilled Nursing Facility	0.0000	0.0000	0.0011	0.0007	$ 406.31	$ 406.31	$ 406.31	$ 406.31
	Chiropractor	0.0187	0.0383	0.1380	0.1002	$ 64.38	$ 64.38	$ 64.38	$ 64.38
	Physical Therapy	0.0454	0.0757	0.0774	0.0738	$ 68.16	$ 68.16	$ 68.16	$ 68.16
	Home Health	0.0175	0.0331	0.0092	0.0162	$ 278.50	$ 278.50	$ 278.50	$ 278.50
	Ambulance	0.0212	0.0064	0.0074	0.0085	$ 393.48	$ 393.48	$ 393.48	$ 393.48
	Durable Medical Equipment	0.0405	0.0221	0.0221	0.0239	$ 328.93	$ 328.93	$ 328.93	$ 328.93
	Audiology Exams	0.0000	0.0018	0.0018	0.0017	$ 91.93	$ 93.43	$ 115.67	$ 107.54
	Dental Care	0.0000	3.0010	3.0010	2.7039	$ 72.74	$ 72.74	$ 72.74	$ 72.74

Exhibit IV - Child Health Plan Plus
Standardized Population

Age	*Projected 1997 Colorado Population*
0	53,107
1	52,777
2	54,040
3	54,375
4	55,875
5	57,106
6	57,295
7	57,769
8	54,393
9	57,578
10	58,257
11	57,685
12	57,100
13	56,528
14	57,943
15	58,539
16	57,654
17	58,276
18	53,920
Total	1,070,217